EXHIBIT 98

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF OHIO
EASTERN DIVISION

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IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION	:	MDL NO. 2804
	:	CASE NO.
THIS DOCUMENT RELATES TO ALL CASES:	:	1:17-MD-2804
	:	Hon. Dan A. Polster

\- - -

Tuesday, January 8, 2019

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HIGHLY CONFIDENTIAL - SUBJECT TO FURTHER CONFIDENTIALITY REVIEW

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Videotaped deposition of DEBORAH BEARER, taken pursuant to notice, was held at the offices of Golkow Litigation Services, One Liberty Place, 1650 Market Street, Suite 5150, Philadelphia, Pennsylvania 19103, beginning at 9:30 a.m., on the above date, before Amanda Dee Maslynsky-Miller, a Certified Realtime Reporter.

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- - -

I N D E X

- - -

Testimony of: DEBORAH BEARER

By Ms. Ruane 10, 308
By Mr. Madden 284
By Ms. Hillyer 303, 373
By Mr. Gastel 313

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NO. DESCRIPTION PAGE

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Question Marked

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None

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(It is hereby stipulated and agreed by and among counsel that sealing, filing and certification are waived; and that all objections, except as to the form of the question, will be reserved until the time of trial.)

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VIDEO TECHNICIAN: We're now on the record. My name is David Lane, videographer for Golkow Litigation Services. Today's date is January 8th, 2019. The time is 9:30 a.m.

This deposition is taking place in Philadelphia, Pennsylvania, in the matter of National Prescription Opioid Litigation. Our deponent today is Deborah Bearer. Counsel will be noted on the stenographic record. The court reporter is Amanda Miller and will now swear in our

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witness.

- - -

DEBORAH BEARER, after having been duly sworn, was examined and testified as follows:

- - -

VIDEO TECHNICIAN: Please begin.

- - -

EXAMINATION

- - -

BY MS. RUANE:

Q. Can you state your name for the record, please?

A. Deborah Bearer.

Q. Ms. Bearer, my name is Sarah Ruane. We met briefly before the deposition. I'm here representing the plaintiffs.

And we talked about the fact that you actually have laryngitis right now; is that correct?

A. Correct.

Q. So I apologize in advance.

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You've been kind enough to still agree to move forward with the deposition right now. I feel like asking you questions -- it sounds like it's painful.

Is it painful for you?

A. No. No, it just sounds bad.

Q. Okay. So if there are any accommodations we can make that help you, just let me know that, all right?

A. Sure. Thank you.

Q. We will probably take breaks about every hour anyway.

A. Okay.

Q. But if you need a break at any time, just let me know.

A. Sure.

Q. Have you given a deposition before?

A. No.

Q. A couple of ground rules, just to make sure we're all communicating, and some of them you may have already heard from your attorney.

But the best way to get a

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clean record is for me to ask a question, full stop, and then you give your answer, rather than speak over each other.

A. Right.

Q. Do you understand that?

A. I do.

Q. And so if any of us start to do that, I may do it as well, somebody will jump in and let us know. We're not trying to be rude, you know, we just want to make sure we get a clean record.

Is that fair?

A. That's fair.

Q. Likewise, you understand you're under oath today, just like if you were before a judge and a jury in a courtroom?

A. Yes.

Q. And that your testimony can be used and played in court?

A. Correct, I understand.

Q. And along those lines, my goal here today is to make sure I leave understanding what you know and what you

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remember.

So I'm going to try to ask good questions, but at some point I will likely ask something that doesn't make sense to you.

If I do that, will you let me know?

A. Yes.

Q. And I will try to restate it and make sure we get on the same page.

But if you answer a question I've asked, I'll assume you've understood it; is that fair?

A. That's fair.

Q. Okay. Let's go ahead and mark as Exhibit-1 your deposition notice.

- - -

(Whereupon, Teva-Bearer Exhibit-1, No Bates, Notice of Deposition, was marked for identification.)

- - -

BY MS. RUANE:

Q. And while I'm doing that,

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let me ask you, what is your current address?
A. 27 Post Road, Newtown Square, Pennsylvania 19073.
Q. And where is Newtown Square?
A. Pennsylvania.
Q. About how far away -- we're in Philadelphia, right?
A. Sorry, sorry.
It is -- it's a 40-minute drive. I will say that it's probably 20 miles.
Q. And are you here pursuant to that Exhibit-1 notice to take your deposition?
A. Yes.
Q. Are you represented by counsel today?
A. Yes.
Q. I think Ms. Hillyer is here acting as your attorney?
A. Yes.
Q. And the attorney for Teva?
A. Yes.

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Q. Do you currently work for Teva?
A. Yes.
Q. And what did you do to prepare for your deposition today?
A. I met with my counsel yesterday. Since I had not been deposed prior, it was just to give me some expectations --
MS. HILLYER: Just make sure that you don't disclose anything that we discussed.
THE WITNESS: No, no.
Just expectations for the day.
BY MS. RUANE:
Q. Got it.
And that's a good point that Ms. Hillyer made. I don't intend to ask you anything about what the two of you discussed.
So if you interpret my question that way, it's never intended to --

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A. Right.
Q. -- to seek that information.
But let me ask you this: Prior to meeting with Ms. Hillyer, did you do anything to refresh your memory about the events in question?
A. No.
Q. When you met with Ms. Hillyer yesterday, how long did you all meet?
A. I'll say eight hours.
Q. And was there anyone else present?
A. Yes.
Q. Were they all attorneys?
A. Yes.
Q. Okay. All attorneys with Ms. Hillyer's office?
A. Yes.
Q. Got it.
During that meeting, did you review documents?
A. Yes.
Q. What types of documents do

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you recall reviewing?
A. Primarily e-mails and some presentations.
Q. Did you -- were you provided a copy or a set of those to take home and review?
A. No.
Q. And what was, just kind of the estimated range of time that those e-mails and presentations encompassed?
A. If I -- I'm not quite sure, but I would have to say probably 2003 to 2014, '15, possibly.
Q. So it's fair to say that within the documents you reviewed yesterday, you saw documents referring to Actiq and Fentora and likely Vantrela as well?
A. Yes.
Q. Did you review any deposition testimony?
A. No.
Q. Did you review any summaries of depositions?

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A. No.
Q. Okay. Have you spoken with anyone at Teva about the testimony they've given or the --
A. No.
Q. Have you spoken with anybody outside of Teva about depositions that have occurred in this case, that aren't attorneys?
A. No.
Q. Okay. Let's back up a little bit. I just want to make sure, since you and I are meeting for the first time, that I have a good understanding of your background.
So I'm going to mark as Exhibit-2 a document. This one is really just --
MS. RUANE: For the record, it's TEVA_MDL_A_09144727.
- - -
(Whereupon, Teva-Bearer Exhibit-2, TEVA_MDL_A_09144727, was marked for identification.)

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- - -
BY MS. RUANE:
Q. And I'll tell you, it's titled, Talent Management Biography. It's a document that was in the production set that I thought may help us kind of more efficiently go through your time with Teva and, I guess, potentially with Cephalon as well.
MS. RUANE: You know what, I'm sorry, I gave you the wrong copy, that's my fault. I should have pulled that one out first.
Becca, would you mind putting the sticker on that? Thank you.
MS. HILLYER: I wrote 2 on that, but I can cover it up.
MS. RUANE: Eventually I'll get my system figured out.
MS. HILLYER: It says 2 -- I mean, I'm sure this will come off.
BY MS. RUANE:
Q. So this is a document that

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was produced to us in the litigation. If you'll turn to Page 2 on it, you'll see, is that a picture of you and some description?
A. Yes, it is.
Q. My first question for you, there's a career overview there. And I just want to make sure that, to you, that looks accurate as far as your time at different companies.
A. Yes.
Q. Where it says, National account manager, was that -- were you serving as national account manager at that point for Cephalon?
A. Yes.
Q. And when did Cephalon become Teva?
A. I believe it was six years ago, seven.
Q. So it's fair to say that your time, as well, as the director of healthcare systems management, was with Cephalon?

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A. Correct.
Q. And then you took over as the director of healthcare systems marketing when it was Cephalon and maintained that title after the company became Teva?
A. Yes.
Q. Okay. Backing up a little bit, what's your educational background?
A. Bachelor of Science degree.
Q. A Bachelor of Science?
A. In business management.
Q. Bachelor of Science in business management.
And then did you start right away, after graduation, as a sales rep in 1983?
A. No. I had a brief time working in retail, commission sales.
Q. Were those pharmaceutical retail?
A. No, no.
Q. So was your first time working in pharmaceuticals -- well,

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strike that.
Let me ask you, when was your first time working in pharmaceuticals?
A. 1983.
Q. Got it.
And during your time as a sales rep there, what were you doing? What were you selling?
A. I was -- we had -- oh, gosh, I'm trying to remember how many products, a broad spectrum of antibiotics, prenatal vitamins, generics.
It was -- back in those days, we carried quite a few products in the bag, if you will.
Q. Did you sell any opioids at that time?
A. No.
Q. And was it at -- I apologize if I'm mispronouncing it, is it Sanofi-Aventis, was that the first time that you had a role in the managed care department?

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A. No. I'm sorry, wait a minute.
Actually, this is not completely correct. At Dupont, when I went to Dupont, so I went from Lederle to Dupont. Being that this is an internal document, this was sort of just --
Q. Yeah. No worries.
A. -- a brief abbreviation.
So I went to Dupont after Lederle, and I was a rep. And then while I was at Dupont, I did about a year of managed care market access. Dupont -- yes, at Dupont.
Q. And it looks like, to me, you've stayed in the managed care arena throughout the rest of your career?
A. Yes, that's correct. Since about 1999 at some point I had a touch point with managed care.
Q. So it's fair to say from 1999 to today, your primary focus of employment is managed care?
A. Correct.

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Q. And managed care -- well, strike that.
Let me ask this: Can you describe for the jury what managed care is?
A. So the words are interchangeable between market access and managed care, because there's been an evolution over time as to what that actually is.
But, basically, what it involves is insurance companies taking ownership and responsibility or financial risk on behalf of the patient or the employee for the employer.
So, for example, Aetna gathers its medical benefits, pharmacy benefits, so there are probably over 100 managed care organizations in the U.S. This continues to evolve over time.
During that time, they make formulary decisions around the access for pharmaceuticals that an employee may have. So if a physician prescribes a

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medication that's not available, say, through Aetna as your pharmacy, then oftentimes it will be denied and other products will be recommended.
That's just a very simplified version.
Q. That's helpful. And I appreciate it.
So during your time -- well, let me ask this first.
When you moved over to Cephalon --
A. Yes.
Q. -- as a national account manager --
A. Yes.
Q. -- was that still in the managed care arena?
A. That is national -- so national account managers are regional account managers for pharmaceuticals with reference to the CLI, calling on managed care organizations, either PBMs, pharmacy benefit managers, or managed care HMOs,

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things of that nature. Not unlike a sales rep would call on a physician.
So it's basically a selling, promoting -- it's a promotional activity. It falls under commercial.
Q. Got it. Okay.
And so at the time that you moved over to Cephalon in 2003, you were doing promotion to managed care entities?
A. Correct.
Q. And in -- am I right that in 2003, then, one of the drugs that you would have been promoting to managed care facilities would have been Actiq?
A. Correct.
Q. And, of course, over time is it -- am I right that it's the kind of 2007-2008 time frame, then, when you all would have started promoting Fentora to managed care facilities?
A. When it was launched it's my understanding it was 2007. I'm not 100 percent certain. It seems correct.
Q. And that's fair. So I

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should have -- let me ask a better question.
We can look up precisely when it was launched, but around that time frame --
A. Yes.
Q. -- whenever it was launched, then, the role of the managed care team was to promote Fentora, amongst others, to the managed care entities?
MS. HILLYER: Objection to form.
You can answer.
THE WITNESS: What?
MS. HILLYER: You can answer.
THE WITNESS: That's -- I want to clarify something.
In 2007, I was not in a payer-facing, customer-facing role.
BY MS. RUANE:
Q. Thank you. And that's a good distinction. So let's clarify that.

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In 2005, you moved over and became the director of healthcare systems management?
A. Yes.
Q. And so -- and was that a supervisory role over national account managers?
A. No, no. That was moving into a home office type of position working with the brand teams, not just for this product but others as well, on the strategy and some of the tactics for each of the products as related to reimbursement.
Q. Got it. So let me try to ask a better question, then.
A. Okay.
Q. In your role, then, from 2007, or whenever Fentora launched, in your role as director of healthcare systems, one of your responsibilities would have been to weigh in on strategy and tactics to improve reimbursement of the drug Fentora?

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A. That's correct.
Q. And one way to do that is to help managed care entities understand, from your perspective and from the company's perspective, that a broader group of indications for prior authorization would be useful and appropriate?
MS. HILLYER: Objection to form.
You can answer if you understand.
THE WITNESS: Could you rephrase it a little bit? Because I --
BY MS. RUANE:
Q. Yes. This is perfect. You're doing the right thing. This is what's going to happen, I'm going to ask bad questions, because I'm in my own head, and I'll rephrase them and we'll get through it together. So let me ask this differently.
What was the change in your

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role after -- from director of healthcare systems management to director of healthcare systems marketing?
A. Okay. You're right. When I was director of healthcare systems management, I managed -- I need to correct something I said earlier, my timeline here.
As the director of healthcare systems management, I was managing six account managers, and they called on the payers.
When I moved into the healthcare systems marketing, that's when I became a home office. So I apologize for that.
The home office position, which -- to state what I stated earlier, worked with the brand team, looked at the strategies related to reimbursement; not only reimbursement in talking with payers, but also reimbursement support services for patients, et cetera.
Q. Got it. Okay. That's

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helpful. And I appreciate that distinction.
And so during the time from 2005 to 2007 --
A. Yes.
Q. -- when you were supervising six account managers --
A. Correct.
Q. -- those account managers would have been calling on managed care entities --
A. Correct.
Q. -- to promote Actiq and then, once the launch date occurred, to promote Fentora?
A. That's correct.
Q. Okay. On that same sheet, if you look under current responsibilities, the first bullet point indicates that you provide market access, marketing support and strategic planning.
A. Yes.
Q. Is that kind of what we've been discussing before --

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A. That's what we've been talking about.
MS. HILLYER: Make sure she finishes the question.
THE WITNESS: I apologize.
MS. HILLYER: That's okay.
MS. RUANE: It's okay.
THE WITNESS: It was 20 minutes before I did that. Sorry.
BY MS. RUANE:
Q. So the market access, marketing support and strategic planning is kind of that brand team strategy and tactics that you've been discussing?
A. Yes.
Q. And you did that for the Fentora product?
A. Yes.
Q. And the second bullet point indicates that you lead cross-functional market access for the Vantrela launch teams?
A. Yes.
Q. Can you explain to me what

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that means?
A. In preparation for the launch, the brand team, the commercial team, has various subteams that feed into the overarching brand strategy.
So market access is one of them. You would have, say, direct-to-consumer, you would have HCP and you would have market access, you might have sales and distribution.
So I led that functional subteam supporting the development of the payer strategy for the launch of Vantrela.
Q. Got it. For the launch of Vantrela.
And on the fourth bullet point there, it indicates that you develop and manage reimbursement support programs.
A. Yes.
Q. What are the reimbursement support programs?
A. And this was a

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collaboration, by the way. Most of these things are -- you know, are in a matrix organization at Teva, so.

Reimbursement support programs, there's a patient assistance program, which is not under my purview, but it is something that I have knowledge of when it comes to the overarching reimbursement and assistance for patients.

There's also the reimbursement hotline, which is for patients and physicians. And I helped facilitate -- there's a vendor, of course, a third party that handles that. So I'm the liaise between the brand, those services, and being, more or less, the content expert for market access and reimbursement.

Q. So it sounds like if there are questions or concerns about the hotline, they would be referred to you as the --

A. Yeah, as the --

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MS. HILLYER: Just let her finish.

MS. RUANE: Sorry. I have a tendency in my questions to trail off as I'm thinking. So that's not your fault, that's my fault. I'll try to fix it.

THE WITNESS: That's okay.

BY MS. RUANE:

Q. Let me restate it.

So it's fair to say that if there were questions or concerns about the hotline program, that they would be referred to you as kind of the leader of that entity?

A. Yes. As with any company, though, obviously, roles and responsibilities often shift a bit.

The brand has a lot of responsibility as well, you know. So we're a support system for the marketing team, the brand team.

Q. And you work pretty closely with the marketing team and brand team?

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A. Yes.

Q. Are some of the individuals on those teams that you work with Matt Day and Randy Spokane, or am I getting my teams mixed up?

A. Can you --

MS. HILLYER: Objection to form. When are you talking about?

MS. RUANE: That's a good point.

MS. HILLYER: And which product?

BY MS. RUANE:

Q. Let's see. Since you've been there since 2003 and we're sitting here in 2018, it's fair to say that over time your roles changed and other people's roles have changed?

A. Correct.

Q. During the time that Actiq was being promoted to managed care entities, did you have interactions with people like Matt Day and Randy Spokane?

MS. HILLYER: Objection to

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form.

You can answer.

THE WITNESS: What do you mean "interactions"? Can you clarify what you mean, "interactions"?

BY MS. RUANE:

Q. Sure.

You mentioned you work closely with the marketing and brand teams.

A. Yes.

Q. Would that have been something that you would have done during that time that Actiq was being promoted to managed care entities?

A. No. Because marketing -- I was in the field, at that time with Actiq, and I was an account manager.

Now, I -- and, by the way, Randy Spokane is not marketing, he's sales. And, yes, I did work with Randy Spokane.

Q. Got it.

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A. Matt Day was in the home office.
MS. RUANE: I'm going to go ahead and mark as Exhibit-3 an employee self-appraisal.
MS. HILLYER: Are we done with 2?
MS. RUANE: Yes.
- - -
(Whereupon, Teva-Bearer Exhibit-3, TEVA_MDL_A_00873333-335, was marked for identification.)
- - -
BY MS. RUANE:
Q. And I know how people love to fill out self-appraisals, so I thought maybe sitting here, 11 years later, we would talk about it again.
But I really actually just pulled it because I think it's a good way for us to just review a couple of the things you were doing around that time.
So this is dated October

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15th, 2007.
MS. RUANE: And, for the record, this is TEVA_MDL_A_00873333 through 3335.
BY MS. RUANE:
Q. A lot of this we've already talked about.
Under objectives and accomplishments, you identify the fact that you're implementing managed care and reimbursement strategy and tactics for optimizing access for all Cephalon products.
Is that consistent with what we talked about, as far as the goal to optimize access to Actiq during the time frame it was involved, and then Fentora?
MS. HILLYER: Hold on a second.
Objection to form.
But you can answer. And take your time to look through it if you need to.
THE WITNESS: I'd like you

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to restate it for me, please.
BY MS. RUANE:
Q. Sure.
We talked about the fact, one of the goals of your role as a -- I guess at this point you would have been a director of healthcare systems marketing, right?
A. Yeah -- no. Let me just make sure. Hold on.
Q. I guess it's the year you switched over, so --
A. Yeah, probably. Because it mentions that I also managed. So I was probably transitioning. I don't really remember, to be honest with you.
Q. Okay. In any event, by October of 2007, one of the things that you defined as an objective and accomplishment was implementing -- and this is just part of that line right under it -- implementing managed care and reimbursement strategy and tactics for optimizing access for all Cephalon

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products?
A. Yes.
Q. And down below, you kind of call out, in a bullet point, Fentora as one of the products that you're tasked with optimizing access to, correct?
A. Correct.
Q. And you include there, in a couple of the bullet points, the things that you're doing as it relates to Fentora.
One of those is, like we talked about, optimizing access and reducing barriers; is that correct?
A. Yes.
Q. The last bullet point under Fentora indicates, Maintained access, 90 percent target accounts.
MS. HILLYER: Where are you?
MS. RUANE: I'm sorry. The last bullet point under Fentora.
The top of 34.
BY MS. RUANE:
Q. Can you explain to me what

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that's referring to?
A. I need to define access for you, because there's different levels of access. It means the patient -- the prescription is prescribed, there may be paperwork involved, et cetera, but at the end of the day, the patient has access to the product.
Sometimes a prescription can be written and it just goes to the pharmacy and you walk away. Other times, there's more hurdles involved.
So what this means is that of the target accounts, this would be referring to when I was managing the account management team, which were those six account managers, and what we were -- we identified target accounts. And of those targets, we wanted to ensure that patients have access to Fentora.
Q. And so how did you identify target accounts?
A. There's many ways in which this is done. Oftentimes, it's done in

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collaboration with the home office marketing team, where you look at the number of covered lives, the geographic footprint, there's -- an example might be in Pittsburgh, Highmark is one of the target accounts. It influences a lot of prescriber behavior, because many patients are enrolled in Highmark.
So there is a strategy -- there is a method to identifying. Most often, it really is related, though, to where the most number of commercial covered lives are.
Sorry, I'm trailing off.
Many times, it's obviously based on enrollment, the larger the plan, the more patients they have. They become a target.
Q. And so you mentioned Highmark as an example in the Pittsburgh area.
But when you would identify managed care entities who had a large enough either geographic footprint or,

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you know -- what did you say about lives? I want to make sure I use the right term.
A. Covered lives.
Q. Covered lives.
A. Think of it as enrollment, same thing, covered lives.
Q. So, basically, the largest numbers of enrollment or covered lives are going to be targets because there's quite a few people who, potentially, could receive access to a drug like Fentora, for example?
MS. HILLYER: Objection to form.
You can answer.
THE WITNESS: My answer is that that's true of any drug, correct.
BY MS. RUANE:
Q. And the way that the managed care team worked on maintaining access to those drugs is kind of detailed in the strategy and tactics for reimbursement that you were involved in?

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MS. HILLYER: Objection to form. What strategies and tactics are you referring to?
MS. RUANE: Let me rephrase that question.
BY MS. RUANE:
Q. We talked about, for example, reimbursement support programs like hot lines, correct?
A. Yes.
Q. Would those be one form of maintaining access?
A. No.
Q. Okay. So what would be forms of maintaining access? What do you do?
A. You call on -- so you provide -- you determine, say, a payer, the account manager goes in, speaks to the plan, provides the clinical information about the product.
The plan can request additional information. They can request information that's non-promotional

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through a medical information request form. Basically, it's negotiating the unmet need -- the benefits of the product and working with the plan to ensure that patients -- that they place it on the formulary so that patients, appropriate patients, have access.

Q. Is it correct that the ultimate goal is to have the medication placed on the formulary?

A. Yes. The alternative is it's blocked.

Q. What is the difference between -- I've also seen reference to prior authorization --

A. Yep.

Q. -- and appeals and letters of medical necessity.

And I'm going to ask you some questions about that in a little bit.

A. Okay.

Q. My first question is, what is the distinction between a drug being

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placed on a formulary and a drug receiving prior authorization?

MS. HILLYER: Objection. That's kind of broad.

But you can answer if you can briefly.

THE WITNESS: I can answer it?

So in order to -- the goal is to get the drug placed on formulary, that's the first step.

There are other things that I'll talk about, if you need more detail. But the -- to answer your question on prior authorization, once the product is on formulary, the plan may determine a prior authorization is required, that the physician fills out, based on the criteria the plans deem appropriate for covering that drug.

It's an administrative effort, most of the time, where

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the doc fills out the form, it's reviewed by the plan, they determine whether it's covered or not; they either say yes or no.

And then if it's yes, the patient has access to the product; if the answer is no, a physician can appeal.

BY MS. RUANE:

Q. Thank you. I appreciate that.

I also wanted to ask, the bullet point just above that indicates, Collaboration and communication with sales teams to identify KOLs.

What are KOLs?

A. Key opinion leaders, physicians.

Q. And did the brand -- strike that.

Did the managed care team utilize key opinion leaders?

MS. HILLYER: Objection to form.

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BY MS. RUANE:

Q. As it relates to Actiq and/or Fentora?

A. Define "utilize."

Q. Did the managed care team have key opinion leaders that spoke to managed care entities?

A. There was a managed care speaker bureau of which, if a plan requested a clinical presentation or a presentation from a clinician, typically those would be considered KOLs. So, yes. In a limited fashion, but yes.

Q. So Teva maintained a managed care speaker bureau, which was kind of a database of key opinion leaders who, at the request of a managed care entity, could be brought in to speak to that entity; am I understanding that correctly?

A. That's correct.

MS. HILLYER: Objection to form.

Go ahead.

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BY MS. RUANE:
Q. Am I understanding that correctly?
A. Restate it, because I --
Q. Sure.
So Teva maintains a managed care speaker bureau of key opinion leaders that they identified. And at the request of a managed care entity, Teva would facilitate one of those key opinion leaders to come in and speak to the managed care entity?
A. Yes.
Q. Okay. Were you involved -- like sitting here right now, offhand, do you know the names of the key opinion leaders that would speak?
MS. HILLYER: Objection to form. When and which product? And which entity?
MS. RUANE: Thank you.
BY MS. RUANE:
Q. With Fentora.
A. Any names?

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Q. Any names.
Do any names come to mind?
A. One name comes to mind, Jeff Gudin.
Q. And were you personally involved in establishing or setting up those key opinion leaders to go in and speak?
A. I was aware. I don't recall being a facilitator of it.
Q. What about during the time that managed care entities were being called on to promote Actiq, are you -- just sitting here today, do you have a memory of the names of any of the key opinion leaders who spoke to managed care entities?
A. During that time, I don't believe any did, that the speaker bureau that we're referring to came later.
So that's why the timing of your question is important. There's been an evolution.
Q. Thank you.

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So if I'm understanding correctly, the managed care speaker bureau is something that applied to the time frame after Fentora was launched?
A. To the best of my recollection, yes.
Q. And when -- if you know, when key opinion leaders were brought in to speak to managed care entities, were they compensated by Teva?
A. Yes.
Q. When -- whether it's the key opinion leader or just a representative from Teva calling on managed care entities, who were the individuals in the managed care entities who were present at those meetings? What roles?
MS. HILLYER: Objection to form. That's compound. You're asking two different scenarios. And it's confusing, because key opinion leaders didn't call on managed care.
MS. RUANE: Let me divide

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them up.
BY MS. RUANE:
Q. When key opinion leaders would come in to speak to managed care entities, as facilitated by Teva, who would be in the audience, if you know?
A. Typically, it would be a pharmacy director, a pharmacy -- clinical pharmacists and medical directors.
Q. And when Teva employees would simply call on managed care entities in order to explain and try to maintain access to their products, who would be in the audience, typically, if you know?
A. Pharmacy directors. Some plans have trade pharmacy contracting. So you have pharmacy and then there would be a contracting arm as well, potentially. And, occasionally, clinical pharmacists. Same audience.
Q. Would the medical directors be present at those as well?
A. That's a broad question.

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Sometimes, I guess, the answer would be.
Q. And, I guess, I kind of assumed this in my question, but I should clarify, just to point out, the managed care entities, we're talking about them as entities, but, obviously, they have employees, some of whom are physicians and some of whom are pharmacists, in your experience?
A. They have both. And in addition to a number of other responsible -- you know, employees.
Q. And the reason I ask is just because I think some people hear managed care entity and they assume it's just a whole bunch of business people.
So in your experience in the managed care entities that you've called on and that you've supervised people calling on, the managed care entities, the decision-makers include physicians and pharmacists as well, correct?
A. Correct.
Q. Okay. And it's fair to say,

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when you were involved in marketing and promoting products like Fentora, that marketing and promotion was going to -- in part, to physicians and pharmacists employed by those managed care entities?
MS. HILLYER: Objection to the form.
You can answer if you understand.
THE WITNESS: Just clarify for me, if you would --
BY MS. RUANE:
Q. Sure.
A. -- what you're asking.
Q. As an example, we've talked about the fact that you all might come up with, you know, a new presentation to give to a managed care entity.
And when you go in to give that presentation, people in the audience included physicians and pharmacists, correct?
A. They could, yes.
Q. They could.

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That was generally your experience? I mean, I get every audience is different. But, generally speaking, that was your experience?
MS. HILLYER: Objection to form.
BY MS. RUANE:
Q. Am I correct?
A. Generally. I would say -- if you're asking me to be general, I would say the majority of times the medical directors were not present, but they could be.
Q. And are the medical directors -- if you know, are the medical directors the ultimate determinate of prior authorization?
MS. HILLYER: Objection. Calls for speculation.
THE WITNESS: I don't know.
BY MS. RUANE:
Q. Okay. Just a couple quick things, and then we'll move on.
On Page 35, so the last page

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of Exhibit-3, under, Fentora brand team --
MS. HILLYER: She's talking about these, 35.
THE WITNESS: Oh, I see.
BY MS. RUANE:
Q. -- it indicates that you participated in the managed care working group for the FAST team, 2008 brand strategy.
A. Yes.
Q. Can you describe for me what that is?
A. I hadn't seen it in a while. I think it was just an acronym for the Fentora action strategic something or other.
It was just -- you know, these are marketing people, they like to name things. But, basically, it was the brand strategy team.
Q. There's a lot of marketing lingo. So I appreciate you know some of it, because it's taken me a while to

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learn some of these.
So the FAST team was kind of one of the names that marketing gave the Fentora launch?
A. As I recall. And as I described earlier, the working group was the subteam that I referred to.
Q. Got it.
And you also participated -- as a result of being part of that Fentora brand team, you participated in the development and review of the Fentora dossier and NAM slide deck?
A. Yes.
That would be the NAM, national account manager, just so you know.
Q. So that was my question. Is the national account manager -- well, strike that. Let me ask this first.
The Fentora dossier and the NAM slide deck, are those specific to managed care?
A. Yes.

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Q. And so prior to Fentora, was there an Actiq dossier or was this a new way of marketing?
MS. HILLYER: Let her finish.
THE WITNESS: I was going to cough.
MS. HILLYER: I thought you were about to answer.
THE WITNESS: No, no.
To the best of my recollection, there was not one for Actiq. This -- as we talked, there's an evolution through managed care. Dossiers became more recognized by plans during this time.
So it's, basically, an AMCP, Academy of Managed Care Pharmacy, dossier format.
And often a company -- now they're electronic, all pharma companies typically, when they're launching a product, provide a

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dossier, upon request, to a plan.
BY MS. RUANE:
Q. You mentioned the -- are you okay?
A. Yes.
Q. Just let me know if you need a break.
A. I will. I'm not shy.
Q. You mentioned in there AMCP. What's AMCP?
A. Academy of Managed Care Pharmacy. It's an organization, like some of the others, that have membership of all the managed care companies, individual membership.
They are like a so-called overseer. They have a journal they produce. They have a large meeting twice a year for pharmacy students. It's not unlike some of the other professional organizations.
Q. Are you a member of that professional organization?
A. No.

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Q. So the -- it sounds like with Fentora -- because of the shift as you described, with Fentora, a dossier and a NAM slide deck was created that would be provided, upon request, to the managed care entities?
A. No. The dossier, yes.
The NAM slide deck is a promotional piece, not unlike a sales aid, that the account manager would use in presenting or talking with a health plan, a payer.
Q. Got it. I feel like it's catching.
So thank you. Let me ask this question again, just to make sure we're clear, and then we'll move on.
So the dossier would be provided, upon request, to the managed care entity. The NAM slide deck was something that was simply used during presentations to managed care entities from a Teva employee?
MS. HILLYER: Objection to

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form.
You can answer.
THE WITNESS: Is that because it's compound?
MS. HILLYER: Yes.
BY MS. RUANE:
Q. I can divide them up --
A. That's okay.
Q. -- if it makes you feel better.
A. The dossier was upon request. The NAM presentation was as you stated.
Q. Got it.
And you participated in the development of those documents, according to --
A. Yes, it says that. But the dossier is typically developed under the medical team.
The only thing that I would say to that, it's probably incorrectly referenced, is it's a compilation of study -- clinical data, any health

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economics data, et cetera. It's not a promotional piece.
I was privy to what was included in the dossier. This NAM slide deck is a promotional piece.
Q. And so dividing them up, you were privy to the information that was contained in the Fentora dossier?
A. Yes.
Q. And you were also -- and am I understanding you correctly that your memory is you did not actually participate in the development of the dossier --
A. No.
Q. -- you just knew what was in it because you were on the e-mails?
A. Yes.
Q. Got it.
With the NAM slide deck, you did participate in the development of the NAM slide deck, correct?
A. As I recall, yes.
Q. Let's move on -- actually,

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before we do, a couple of things I just want to make sure.
I've asked several questions of you already about kind of marketing terms or things that I don't understand within this, and you've been kind enough to define them so far.
There's a couple of other things I want to make sure we're on the same page about.
Do you agree that during the time -- well, actually, the entire time that Actiq was being sold that the indication for Actiq was for breakthrough pain in cancer patients?
A. That's the label.
Q. And I guess the full title would be, For breakthrough pain in cancer patients who are opioid tolerant, correct?
A. Correct.
Q. Okay. And that was true the entire time that Actiq was being sold, correct?

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A. Correct.
Q. Do you also agree that the indication for Fentora was for breakthrough cancer pain in patients who are opioid tolerant?
A. Cancer pain, yes.
Q. For breakthrough cancer pain, correct?
A. Yes.
Q. And so you understood that it was illegal to market or promote those products off label?
MS. HILLYER: Objection. Calls for a legal conclusion.
MS. RUANE: You can answer.
THE WITNESS: I'm not an attorney.
BY MS. RUANE:
Q. In your role working with managed care entities, you had an understanding about what on label was, correct? We just talked about it.
MS. HILLYER: Objection to form.

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But you can answer.
THE WITNESS: I understand what the label -- I understand what the indication in the label stated, yes.
BY MS. RUANE:
Q. And the indication of the label would be on-label use of those products.
So that would be if a physician prescribed -- let's take Fentora, for example. If a physician prescribed Fentora for breakthrough pain in a patient that he or she had who had cancer and was opioid tolerant, that would be on-label prescribing, correct?
A. Correct.
Q. Okay. You also understood that there was the potential for off-label prescribing by physicians to prescribe the product for breakthrough pain in a patient who didn't have cancer, for example, correct?
A. Correct.

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Q. And you --
A. Sorry.
Q. Sorry?
A. Correct.
Q. And you understood, in your role with both Cephalon and Teva, that it would be illegal to market or promote the use of Actiq and Fentora for anything other than on-label use?
MS. HILLYER: Objection. Asked and answered. And calls for a legal conclusion.
MS. RUANE: You can answer.
THE WITNESS: Say it again. Sorry.
BY MS. RUANE:
Q. Sure.
You understood --
A. Right.
Q. -- during the time that you've been employed by Cephalon and then Teva --
A. Right.
Q. -- that it is illegal to

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promote products off label, correct?
MS. HILLYER: Same objection. Asked and answered. And calls for a legal conclusion.
You can answer if you can.
THE WITNESS: Based on the way you phrased the question, I would answer yes.
BY MS. RUANE:
Q. And you knew that the reason it was illegal to promote Fentora, as an example, off label, was because the FDA indication was limited to breakthrough cancer pain in opioid-tolerant patients, correct?
MS. HILLYER: Objection to form. And calls for a legal conclusion.
MS. RUANE: Would you like me to rephrase it, or are you able to answer?
THE WITNESS: I think the answer is -- rephrase it, because I want to make sure I answer

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correctly.
BY MS. RUANE:
Q. Sure.
So we know that you understood off-label marketing, marketing or promoting a product like Fentora for something beyond breakthrough cancer pain in opioid-tolerant patients, was against the law, right?
MS. HILLYER: Same objection. Asked and answered. And calls for a legal conclusion.
BY MS. RUANE:
Q. That's correct?
A. Yes.
Q. And describing pain as, pain is pain, or breakthrough cancer pain is the same thing as breakthrough pain is off-label marketing, isn't it?
MS. HILLYER: Objection to form.
THE WITNESS: I don't -- I don't -- I don't think that you're accurate, no.

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BY MS. RUANE:
Q. You agree that the only on-label use for both Actiq and Fentora was breakthrough cancer pain, correct?
MS. HILLYER: Objection to form.
You can answer.
THE WITNESS: The indication, you're correct.
BY MS. RUANE:
Q. And so any promotion or marketing which attempted to expand the idea of pain from breakthrough cancer pain to breakthrough pain would be off-label marketing, wouldn't it?
MS. HILLYER: Objection to form. That's confusing.
THE WITNESS: I mean, that's too vague.
BY MS. RUANE:
Q. Do you believe that marketing a product like Fentora for breakthrough pain, without any reference to cancer, is off-label marketing?

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MS. HILLYER: Objection to form. It calls for a legal conclusion.
THE WITNESS: In the context that you're stating, which I think is pretty broad, I would agree with you.
BY MS. RUANE:
Q. And so it's important that the phrase "pain is pain" be well defined; because if "pain is pain" is actually addressing the argument that breakthrough cancer pain and breakthrough pain of any other sort are the exact same thing, that would be off-label marketing, wouldn't it?
MS. HILLYER: Objection to form. Calls for legal conclusion. Argumentative. And vague.
You can answer if you understand the questions.
THE WITNESS: I'm not familiar with the "pain is pain" relative to any of my experience

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within the organization. So I can't answer it.
BY MS. RUANE:
Q. Okay. Thank you. And that's a fair point.
So in your memory, you have never used the phrase "pain is pain" --
A. No.
Sorry.
Q. And let me ask it again, just to make sure we're not stepping on each other.
In your memory, you have not used the phrase "pain is pain" in the promotion or marketing of an opioid product?
A. Not to my recollection.
Q. And using the phrase "pain is pain" in marketing an opioid product like Fentora would be off-label marketing, wouldn't it?
MS. HILLYER: Objection. Very vague. And calls for a legal conclusion.

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Any opioid product?
MS. RUANE: I said Fentora.
MS. HILLYER: You said like Fentora.
MS. RUANE: Let me ask it again.
BY MS. RUANE:
Q. Would you have allowed, in your role as managed care -- as -- excuse me.
Would you have allowed, in your role as director of healthcare systems marketing, to -- an employee of yours to market to a managed care entity the use of Fentora with the description, pain is pain?
MS. HILLYER: Objection to form.
THE WITNESS: There was no direction from me to any of my team to make that statement, ever.
BY MS. RUANE:
Q. And you wouldn't direct anyone to make that statement because

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that would be off-label marketing, wouldn't it?
A. It's vague.
MS. HILLYER: Objection to form.
THE WITNESS: In context, I don't -- I don't think I can agree with you.
BY MS. RUANE:
Q. You don't think -- I want to make sure I understand. If you're not agreeing with me, I want to make sure I understand why.
In your role as director, you would not have authorized, and you don't believe you would -- you did ever authorize, the use of the phrase "pain is pain" in promotion or marketing of Fentora?
A. That's correct.
Q. And the reason -- I mean, you obviously have no memory of it.
But the reason -- am I correct that the reason you think you

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would not have authorized that is because that would be marketing the product beyond its indication of breakthrough cancer pain?
MS. HILLYER: Objection to form.
THE WITNESS: I could see a situation in which you're having -- you're just making a statement of what I would say is context, or maybe opportunities to have a conversation, in which you're talking about pain management.
But we always stuck to the label, as far as what the indication is for our product.
So there's, obviously, conversations that people have relative to pain management. But in terms of actually promoting and recommending it, as it relates to Fentora, that would not happen.
BY MS. RUANE:

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Q. Okay. And if it did happen, it would have been off-label marketing, correct?
MS. HILLYER: Objection to form.
THE WITNESS: Again, there's various types of pain. You're probably aware. There's nociceptive pain, neuropathic pain.
So, again, I see this as a very strong, broad statement. If you want to get specific about all the different types of pain, low back pain and all that, then we can talk about that.
BY MS. RUANE:
Q. And there are.
And, in fact, at some point, Teva authored and issued letters of medical necessity on different types of pain, correct?
MS. HILLYER: Objection.
BY MS. RUANE:

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Q. Including back pain?
MS. HILLYER: Objection. Assumes facts not in evidence.
BY MS. RUANE:
Q. We can look at them in a little bit. I'm just asking if you remember.
A. I believe so, yes.
Q. My question for you is a little bit different.
If the description of "pain is pain" was being used in reference to breakthrough cancer pain, and any other breakthrough pain in a patient who doesn't have cancer, is the same because all pain is pain, that would have been off-label marketing, correct?
MS. HILLYER: Objection to form.
THE WITNESS: Again, I feel -- I'm going to give you a yes, in the sense of you're pushing me to state something that I believe is somewhat out of

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context.
Because I have not seen anything specific to pain is pain.
BY MS. RUANE:
Q. But given the information I provided you, you would agree with that statement?
A. I'm not an expert on all the nuances of off-label promotion.
But based on the way you have asked me, a number of times, I would answer, to the best of my knowledge, the way that you've asked the question, yes.
Q. Okay. Let's move on to Exhibit-4.
MS. HILLYER: We've been going about an hour. Do you want to take a quick break?
MS. RUANE: That's perfect. Let's take a break.
VIDEO TECHNICIAN: Going off record. 10:29 a.m.
- - -
(Whereupon, a brief recess

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was taken.)
- - -
VIDEO TECHNICIAN: Back on record. 10:42 a.m.
BY MS. RUANE:
Q. Back on record after a short break.
You understand you're still under oath?
A. I do.
Q. Okay. We're going to hand you Exhibit-4, Bates range TEVA_MDL_A_04838673 to 77.
- - -
(Whereupon, Teva-Bearer Exhibit-4, TEVA_MDL_A_04838673-677, was marked for identification.)
- - -
BY MS. RUANE:
Q. This is a document you authored as the national account manager --
A. Okay.

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Q. -- correct?
MS. HILLYER: Take your time to look it through.
THE WITNESS: Okay. Yes, my name is on it, and it looks familiar.
BY MS. RUANE:
Q. The first page, Page 73, you'll see an advocacy bullet point there?
A. Yes.
Q. That indicates, Advocacy-cultivate key physicians in each target market to assist in influencing key account formulary committees, establishing PA criteria and guidelines, challenging existing restrictions, et cetera.
And then, Coordinate peer-to-peer discussions and share best practices.
Is that correct?
A. That's what it says, yes.
Q. Got it.

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We talked about the goal to get, I guess at this point it would have been Actiq, on to the formulary?
MS. HILLYER: Objection to form.
BY MS. RUANE:
Q. We talked about that, prior?
A. You're implying that it wasn't on formulary. This is -- these are global objectives for all brands.
Q. Okay. One of the goals with Actiq was to make sure that -- or to get it on to formulary, if it wasn't, correct?
A. Yes.
Q. And so you influenced -- your goal was to cultivate key physicians to assist in influencing key account formulary committees for that purpose, correct?
A. That's correct.
Q. We've also talked about prior authorization and you explained how that works.

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One of the goals was to establish prior authorization criteria and guidelines and to challenge existing restrictions, correct?
A. This is a broad statement.
We don't know what the restrictions are. In general. It's a broad objective.
Q. And that would have been true as it relates to Actiq, to challenge whatever existing restrictions there were regarding prior authorization, correct?
MS. HILLYER: Objection to form.
THE WITNESS: Again, a broad statement. There may be restrictions that are appropriate.
So just to make a blanket statement about restrictions doesn't imply that some -- prior authorizations often include very appropriate restrictions as well, like, for example, tolerance to opioid, opioid tolerance. That

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would be considered a restriction that is appropriate.
BY MS. RUANE:
Q. What about cancer pain, was that considered a restriction that was appropriate for Actiq?
MS. HILLYER: Objection to form.
THE WITNESS: That is -- let me state first that for both Actiq, as it evolved in the marketplace, prior authorizations were required. Often they default to label. Often they can include beyond label. It depends.
So there's not one answer to your question.
BY MS. RUANE:
Q. Okay. My question for you, as the national account manager who drafted this document --
A. Yes.
Q. -- was, you gave the example of opioid-tolerant patients as an

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appropriate indication that wouldn't -- that you wouldn't attempt to establish prior authorization criteria beyond; is that correct?
MS. HILLYER: Objection to form. Mischaracterizes testimony.
THE WITNESS: That's not what I said.
BY MS. RUANE:
Q. What was your example for opioid-tolerant patients? What were you referring to?
A. What I'm referring to is, for everyone's edification, prior authorizations often have very specific requirements, it's called criteria, not necessarily restrictions, criteria that the plan determines.
Each plan makes their own determination, based on the clinical data and what's available to them from what's going on in the marketplace.
If they choose to cover it beyond label, that's their privilege to

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do so.
And each plan, if you were to look at a prior authorization form, might have very specific criteria that varies from one plan to another. And that is up to the P&T committee and the clinical team for that health plan.
Q. And one of the goals, as a national account manager at that time, was to assist in establishing that prior authorization criteria, correct?
A. It depends. It's part of the -- you have a clinical discussion with the team -- with the plan. And they write their PA criteria, we do not.
Q. And at least at that time, on Page 74, under, Anthem pharmacy services --
A. Yep.
Q. -- the fourth bullet point down, it looks like, to the extent Actiq had updated clinical information, that was going to be provided?
A. That's what it says, yes.

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Q. Let's turn to Page 77, it's the last page.
You'll see there, there's a heading, Manage resources effectively?
A. Uh-huh.
Q. The second-to-last bullet point indicates, Learn and utilize Actiq white paper, when available, to present data to plans.
A. That's what it says.
Q. Is the Actiq white paper the same as the dossier?
A. No.
Q. What was the Actiq white paper?
A. I honestly don't remember. I remember there was one, but I don't recall specifically what it was.
Q. Do you recall who was involved in creating it?
A. I honestly don't.
- - -
(Whereupon, Teva-Bearer Exhibit-5,

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TEVA_MDL_A_04838485-490, was marked for identification.)
- - -
BY MS. RUANE:
Q. I'm going to hand you what's been marked as Exhibit-5.
This is a similar document, just for 2005, correct?
MS. HILLYER: Take your time to look it over.
BY MS. RUANE:
Q. And I'll tell you -- I mean, take the time you need. But I'll tell you I'm just going to ask you one or two questions, and then we'll move on.
A. Okay.
Q. On Page 2 of that document, 86, it's, I guess, the -- it's hard to describe, right above Cigna, I guess, the last bullet point right above Cigna, one of the things included was to broaden the Actiq prior authorization criteria?
A. Yep.
Q. And below that is an MEP on

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pain management, correct?
A. Correct.
Q. What's an MEP?
A. Medical education program.
Q. And so medical education programs would be provided to managed care entities with the goal of broadening the Actiq prior authorization criteria, correct?
A. Not necessarily. Managed care organizations don't treat patients, so we spend a lot of time with medical education programs, particularly in the pain area.
And you give them -- it's like a disease state type of presentation to educate them, because we can't assume that every pharmacy director has working knowledge of all the different therapeutic areas or all the medications.
Q. And in this case, the pain management education is referenced, below the goal, to broaden Actiq prior authorization criteria; you would agree?

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A. That's what it says.
Q. Okay. And there's also an indication that the team is going to work with the field to drive appeals and letters of medical necessity, correct?
A. That's what it says.
Q. That's also under the heading of, Broaden Actiq prior authorization criteria, correct?
A. Correct.
Q. And the field would be individuals -- sales representatives calling on physicians, correct?
A. Let me make sure I'm answering you correctly.
Field -- yes.
Q. And the sales representatives calling on the field -- or within the field would be tasked with, rather than having their -- the physicians they call on accept a denial, to undergo the appeal process and, if necessary, submit a letter of medical necessity, correct?

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MS. HILLYER: Objection. Calls for speculation. Lack of foundation.
THE WITNESS: Why don't you rephrase?
BY MS. RUANE:
Q. Sure.
When it says, Work with the field to drive appeals and letters of medical necessity, that is to drive an increase in the number of appeals and letters of medical necessity, correct?
MS. HILLYER: Objection. Calls for speculation.
THE WITNESS: This was a time when prior authorizations, letters of medical necessity, was not as commonplace for many offices.
The idea behind prior authorizations and letters of medical necessity was to ensure that the office staff was familiar with the process, to ensure

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appropriate patients, as deemed appropriate by the physician, had access to Fentora.
BY MS. RUANE:
Q. And so to drive the number of appeals and letters of medical necessity would have the effect of increasing, potentially, the number of patients who, although they were first denied, upon appeal and submission of a letter of medical necessity, were able to receive the opioid, correct?
MS. HILLYER: Objection to form.
THE WITNESS: While I'll state that you're -- the prior authorization, the reasons for denials of prior authorizations are many, many; not just based on diagnosis and indication. So I want to clarify that.
BY MS. RUANE:
Q. And I appreciate that.
The practical effect of a

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denial is that medication is not going to be paid for and the patient won't receive the medication, correct?
A. That's part of it. It could be that the information is not complete, the requirement for prior therapies is not documented.
So, like I say, there are many reasons why prior authorizations are denied.
Q. And my question was a little different.
The practical effect of that, if there's a denial, is that medication is not going to be paid for, the patient is not going to receive that medication, correct?
A. The patient can pay cash, but the payer is not going to pay for it.
Q. If the patient doesn't pay cash, excluding an out-of-pocket payment, then the practical effect would be the patient doesn't receive the medication -- that medication, correct?

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A. Correct.
Q. And so Teva, or Cephalon, I guess at this time --
A. Right.
Q. -- doesn't receive that profit, correct?
A. The script won't be filled.
Q. And Teva, or Cephalon at that time, doesn't receive the profit for that script, correct?
MS. HILLYER: Objection to form.
But you can answer.
BY MS. RUANE:
Q. That's a true statement, isn't it?
MS. HILLYER: Same objection.
THE WITNESS: That sales -- sale would not be recognized by Teva or Cephalon.
BY MS. RUANE:
Q. The sale wouldn't be recognized, and Teva or Cephalon wouldn't

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receive the money, correct?
A. Unless the patient paid cash.
Q. And so one of the goals, in order to increase the profits, would be to utilize appeals and letters of medical necessity in order to drive and increase the number of patients who receive, at this time, Actiq, correct?
MS. HILLYER: Objection to form.
THE WITNESS: The premise for driving appeals and/or educating the staff is to ensure the patient had access. The result of that, of course, would be Cephalon would receive a sale.
BY MS. RUANE:
Q. Okay.
A. Appropriate patients having access.
Q. And that process has continued, as far as -- strike that.
Let me ask a better

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question. The process of utilizing appeals and letters of medical necessity in order to assist in patients receiving the medication continued with Fentora, correct?
MS. HILLYER: Objection to the form.
THE WITNESS: I'm trying to remember. There were various discussions around what letters of medical necessity would be available.
I believe we did have them for Fentora, as I recall.
BY MS. RUANE:
Q. Okay.
A. And mind you, letters of medical necessity are managed through our medical department, not me.
Q. On Page 87, toward the very bottom, it's actually the second bullet point above Eckerd Health Services, it indicates, Continue to develop relationships with local Actiq advocates.

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A. Yep.
Q. So the -- are "local Actiq advocates" physicians who prescribe Actiq?
A. Yes.
Q. And one of the things you were tasked with, in your role, was to continue to develop those relationships, correct?
A. Typically, working with sales teams not individually.
Q. So what you would do would be to coordinate with the sales teams in order to ensure that they were developing positive relationships with the physicians who you all considered to be Actiq advocates?
A. That's true with every product.
Q. That's also true with the Fentora product, correct?
A. It's true with any -- that's a standard practice in the industry.
And I'll clarify. When

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products may or may not be added to formulary, many times pain specialists are not a part of their P&T, so they rely on those physicians we're referring to for input in the decision-making.
Rarely have I ever seen or heard of a pain specialist sitting on a P&T committee that ultimately makes the decision as to whether it's on formulary and what the criteria covered -- what the coverage criteria is.
Q. So breaking that up, the P&T committee is the committee that decides whether a drug ends up on formulary, correct?
A. They make a recommendation. And then there's a financial piece to it that the contracting side or the trade side of the plan makes a determination, based on the cost of the drug, et cetera.
Q. So the P&T committee makes the recommendation on whether a drug should end up on formulary, correct?
A. Yes.

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Q. And Cephalon, and then Teva, recognized that utilizing physician advocates who advocate for their products was a helpful step in obtaining formulary status for their products?

MS. HILLYER: Objection to form.

THE WITNESS: It's a broad statement, because there's no suggestion of -- I mean, if a plan decides not to cover it at all, you need an advocate to say, we need this product.

It has nothing to do with what the indication is, or what have you, at that point.

BY MS. RUANE:

Q. I'm sorry?

A. So what I'm trying to say is, yes, physicians are often tasked, with their expertise in certain specialty areas, for making -- giving opinions to the P&T committee, clinical -- based on their practice.

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Q. And the role that Teva plays in that is to maintain relationships with those physicians?

MS. HILLYER: Objection to form.

THE WITNESS: Teva?

BY MS. RUANE:

Q. And Cephalon.

A. But you're -- it's a broad -- I mean, who? Who in Teva?

Q. Well, my question is, because on your managed care and reimbursement objectives, one of your bullet points is to continue to develop relationships with local Actiq advocates.

A. Yes.

Q. So my question is posed to you because that's in a document that has your name on it.

A. Okay.

Q. Would you agree --

A. That was an objective.

Q. -- that was an objective?

A. Sorry.

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Q. And that was also an objective with the Fentora product, correct?

MS. HILLYER: Asked and answered.

You can answer again.

THE WITNESS: Again, going back to the timeline, the majority of my involvement with Fentora was not customer-facing.

BY MS. RUANE:

Q. But in your role at Teva, you were aware of the fact that the goal of maintaining relationships with patient advocates in order to make sure there's somebody to advocate for Fentora on the formulary maintained a goal of the organization, correct?

A. You stated patient --

MS. HILLYER: Objection to form.

THE WITNESS: You stated patient advocate. You said patient advocate.

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BY MS. RUANE:

Q. Let me ask the question again.

In your role, though your position changed, but you're aware of the fact that it maintained -- that Teva maintained, as a goal, to develop relationships with advocates for Fentora in order to, hopefully, provide somebody to advocate for the use of Fentora on the formulary?

A. So as I stated in previous comments relative to the landscape of managed care, back when Actiq was promoted, many times the role of an account manager was just as you stated in the objectives.

That evolved into a very relatively ineffective way to have physician advocates. It's really up to the sales representatives in the marketplace to promote the product appropriately to all physicians, whether they are KOLs or not.

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So the practice of -- of an account manager personally getting to know a KOL was really not the norm in the Fentora time frame.
Q. So that was a shift from a practice that occurred with Actiq?
A. Yes, I would say it is.
Q. Okay.
A. And -- yes.
Q. All right.
- - -
(Whereupon, Teva-Bearer Exhibit-6, TEVA_MDL_A_04484212-214, was marked for identification.)
- - -
MS. RUANE: I'm going to hand you what's been marked as Exhibit-6. For the record, this is TEVA_MDL_A_04484212 through 14.
BY MS. RUANE:
Q. If you look down to the second message there, the e-mail from Terry Terifay.

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Are you cc'd on this e-mail?
A. The second one, yes.
Q. And this is referencing that Actiq white paper --
A. Okay.
Q. -- that we talked about earlier?
MS. HILLYER: Take your time to look through it if you need to.
THE WITNESS: Okay. Yes.
BY MS. RUANE:
Q. Terry's e-mail, on which you were cc'd, indicates that, in the first line, This document is going to be a great initiative as we roll out our 2005 tactics to address issues around reimbursement for Actiq.
Did I read that correctly?
A. Wait a minute. This one here?
Sorry. I was looking -- yes, that's what it says. Sorry.
Q. So this Actiq white paper was going to be used with managed care

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entities, correct?
A. Yes.
Q. And the Actiq white paper was circulated to a certain set of Cephalon employees, some of whom provided feedback, correct?
A. I don't, truthfully, recall this. Now that I'm reading it, it's familiar.
Q. Okay. And you were included on the e-mail chain with the feedback, correct?
A. That was routine, to be cc'd.
Q. I'm sorry, what did you say?
A. It was -- it was routine for -- you notice I was cc'd by Terry because I was more of the marketing.
So he would automatically copy me on things.
Q. And in the message below, on which you're cc'd, Bill Cunningham -- it's the last sentence on Page 212.
A. Yep.

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Q. We'll talk about the feedback itself in a minute.
But Bill indicates, Essentially, the reason behind the need to have the commentary section worded in such a way is to ensure that managed care clearly understands the nature of what is being discussed and does not attempt to misconstrue or misinterpret the information.
Do you see that?
A. I see that.
Q. He goes on and talks about the fact that he doesn't want managed care to attempt to turn the intent of the information around and possibly use it to their own advantage.
Do you see that?
A. I see that.
Q. Do you have an understanding of what he meant by that?
A. I do not.
MS. HILLYER: Objection. Calls for speculation.

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BY MS. RUANE:
Q. You do not?
A. No, I don't know.
Q. Okay. Feedback was provided, below that, by Joseph -- I may be mispronouncing it -- Duarte.
A. Correct.
Q. Do you know Joseph Duarte?
A. Yes.
Q. Does he have any medical or pharmaceutical training, to your knowledge?
A. I don't know.
Q. One of the things -- do you know what Joseph's role was with the company?
Actually, I say that. Look on Page 214, he's listed as a national account manager?
A. Yes. He was a national account manager.
Q. And do you know what bucket, I mean, what -- do you know, was he in managed care? Strike that. Let me ask

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it that way.
Was he in the managed care group?
A. Yes. National account manager.
Q. For managed care?
A. Yes.
Q. He, it looks like, offices out of California?
A. Correct.
Q. To your knowledge -- well, strike that, let me ask this.
Joe had reviewed the Actiq white paper. And under Number 2, so I'm on Page 213, in bold, he gives his suggestions. And he is talking about Module 1.
It looks like it said, Breakthrough pain, defined as a transient flare in pain of moderate-to-severe intensity occurring in conjunction with persistent pain, is a prevalent form of pain in patients with cancer or other terminal diseases.

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Do you see that?
A. I see. Yes. I'm sorry, yes, I do.
Q. Do you see the suggestion -- he gave a couple different suggestions. One was just to omit the whole thing and end that sentence with, you know, Persistent pain is a prevalent form of pain in patients.
Do you see that?
MS. HILLYER: Objection. I just want to be clear that it looks like other people may have commented. And because this isn't in color, it's not clear whose comments are whose.
MS. RUANE: That's fair.
MS. HILLYER: But go ahead.
BY MS. RUANE:
Q. So within the -- the only reason I ask it that way is because at that point it looks like it's an e-mail just with Bill and Joe.
But there may have been

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others.
MS. HILLYER: Terry had comments, it looks like, perhaps.
BY MS. RUANE:
Q. On that July 12th, 2004 e-mail, he gives three suggestions, correct?
MS. HILLYER: Same -- same objection.
Go ahead.
BY MS. RUANE:
Q. Do you see that he gives three suggestions there?
A. I see there are three suggestions there.
I also notice that the font is different on C, so I don't know, based on what I'm reading here, if, in fact, that is actually what -- his comment. I don't know.
Q. Got it.
Whoever's suggestions they are, every -- all three suggestions do not limit that definition of breakthrough

pain to patients with cancer; is that correct?
A. That's correct.
Q. If you'll flip the page to Page 214, Number 6 there on Module 2, there's a question about whether they can include the Turk editorial titled, Remember the Distinction Between Malignant and Benign Pain? Well, forget it.
Do you see that?
A. Yes, I see it.
Q. So those were requests made by somebody within the Cephalon company, as far as edits to the Actiq white paper, correct?
MS. HILLYER: Objection to the form.
You can answer.
THE WITNESS: What I don't remember is if this was more or less a disease state type of document. I don't remember.
If it was, then it would

make sense to have a distinction, you know, between -- there's malignant and nonmalignant pain, more of an education. That's what I don't remember.
So just looking at this, I can't answer your question specifically.
BY MS. RUANE:
Q. We know it's titled, The Actiq White Paper --
A. Yes.
Q. -- right?
Is that correct?
A. Yes.
Q. And so the Actiq white paper --
A. Okay.
Q. -- would reference the drug Actiq rather than a more general disease state.
Do you agree?
A. I think if -- without seeing the deck itself in the context of the

flow, oftentimes we would have promotional decks or decks that would give disease state awareness up front, that's very common, and then go into the product. I have examples currently that I use.
The slides themselves -- and I don't remember, but I'm just educating you, the slides themselves, anything that is nonbranded would have a different template, and then transition into a branded template when you start speaking about the product.
Q. And --
A. So --
Q. And you don't remember, one way or another, with this Actiq white paper?
A. I really don't, sorry.
Q. Based on the names included on this e-mail, if you just look at Page 2, I think all the names are included in the July 20th, 2004 portion of the e-mail, on Page 212, where Terry sends it

out and cc's you, can you tell me, based on your knowledge, whether anyone on that e-mail has any medical training as a physician or a pharmacist?
A. I know for a fact Susan Larijani does, she's in medical services. I don't know the background of Joe, other than my relationship with him at Cephalon.
Andy Pyfer is -- I don't believe has medical. Nor Bill.
Q. Do you happen to know what Susan's training is?
A. No.
MS. RUANE: I'm going to hand you Exhibit-7, which, for the record, is TEVA_MDL_A_04478352 through 356.
- - -
(Whereupon, Teva-Bearer Exhibit-7, TEVA_MDL_A_04478352-356, was marked for identification.)
- - -

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MS. HILLYER: This is 7, you said?
MS. RUANE: Yes.
BY MS. RUANE:
Q. This is a follow-up e-mail. Susan indicates, on the first page in the first sentence, Q and I have reviewed your collective comments and I have incorporated most of them in to the final document.
Do you see that?
A. I do.
Q. Do you have any idea who Q is?
A. Medical director.
Q. And that would have been the medical director for --
A. Pain.
Q. Pain.
What's Q's full name?
A. It's in the cc at the top. They called him Q, but it's K-I-U-M --
Q. Got it.
So for the record, that's

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K-I-U-M-A-R-S; last name, V-A-D-I-E-I?
A. Correct.
Q. I'm not going to try to pronounce that.
A. That's why he was called Q.
Q. In any event, in this document Susan includes, for example, on Number 2, Subparagraph D, what the revision is going to be.
Do you see that?
A. I do.
Q. And ultimately, after reviewing the comments, the revision to the Actiq white paper referenced, Breakthrough pain, defined as a transient flare in pain of moderate-to-severe intensity occurring in conjunction with persistent pain, is a prevalent form of pain in patients with malignant and nonmalignant diseases.
Do you see that?
A. I do.
Q. You would agree that's beyond the scope of breakthrough pain in

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cancer patients?
MS. HILLYER: Objection to form.
THE WITNESS: Again, I would love to see the final deck, because these are only recommendations.
BY MS. RUANE:
Q. We'll get there.
A. Good. Because I don't -- I'm answering you based on what I'm seeing here.
I'm assuming the highlight is included in the revision, so she added it back in. Because it seems like the last one was a deletion if it was highlighted, or no?
Q. Yes. That's correct. There were several options.
The one it appears they landed on referenced a prevalent form of pain in patients with malignant and nonmalignant diseases, correct?
A. That would be appropriate in

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the disease state slide, for example.
Q. And you would agree that that revision references disease states beyond the scope of breakthrough cancer pain, correct?
A. That's what it states.
Q. Okay. So my statement is correct?
A. Yes.
Q. Under Module 2, it's actually just Number 3 there, the revision that they landed on, it states -- and I apologize, it's a little dark -- The use of opioids for the management of cancer pain is well accepted and the use of opioids for the management of nonmalignant pain is gaining wider acceptance among pain care specialists.
Do you see that?
A. Yes.
Q. And then it goes on, Several professional societies -- but it's not a full sentence, right, at least in this

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form?
A. Correct.
Q. So this document references the use of opioids for the management of nonmalignant pain, correct?
A. Yep. Yes.
Q. So that is not just a disease state presentation, correct?
MS. HILLYER: Objection to form.
THE WITNESS: I don't know.
BY MS. RUANE:
Q. It is referencing, you would agree, the use of opioids, correct?
A. Yes.
Q. And it's referencing the use of opioids for management of nonmalignant pain, correct?
A. Yes.
Q. And you would agree that that's referencing the use of opioids for something beyond breakthrough cancer pain, correct?
A. Opioids in general, yes.

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Q. In an Actiq white paper, right?
A. That's what I'd like -- yes. Yes.
It's not uncommon to include standards of care, et cetera, in what we would consider -- I'm assuming this is promotion, but it's not uncommon to do that.
- - -
(Whereupon, Teva-Bearer Exhibit-8, TEVA_MDL_A_10070409-410, was marked for identification.)
- - -
MS. RUANE: I'm going to hand you what's been marked as Exhibit-8. This is TEVA_MDL_A_10070409 to 410.
BY MS. RUANE:
Q. The second paragraph -- this one I'll be brief on.
But the second entry, I guess, from Joe Duarte again, he's

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requesting the addition of Dr. Tennant's study to the Actiq white paper. And that study is entitled, The Use of Oral Transmucosal Fentanyl Citrate for Breakthrough Pain in Severe, Nonmalignant Chronic Pain.
Do you see that?
A. I do.
Q. And so is that consistent with your memory that the Actiq white papers would provide medical studies?
A. So I remember -- I stated earlier, I don't recall a lot of detail about the white paper.
After reading this, when I see professional services, that would come from our medical side, which is where Susan Larijani resided. Therefore, this is not a promotional piece.
Q. Am I understanding you correctly that what you're saying is the Actiq white paper is not a promotional piece?
A. Right. Based on my

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recollection now, after referring to professional services. And, typically, anything coming from professional services would be upon request, unsolicited request from a physician.
Q. So if it's not --
A. I'm sorry. Not a physician, a plan. Sorry.
Q. Got it.
So if it's not a promotional piece -- the significance to you of the fact that it's -- the Actiq white paper is not a promotional piece is that it means it's not used by you or others when you're calling on --
A. Correct.
Q. -- managed care entities?
MS. HILLYER: Make sure she finishes.
BY MS. RUANE:
Q. I'll do it again, just to be sure we're tracking.
The significance to you of the fact that, in your mind, the Actiq

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white paper was not a promotional piece is that it was not used by you or others when you're calling upon managed care entities?
A. Correct.
Q. Okay. Great.
- - -
(Whereupon, Teva-Bearer Exhibit-9, TEVA_MDL_A_04426360-362, was marked for identification.)
- - -
MS. RUANE: I'm going to hand you what's been marked as Exhibit-9. This is, for the record, TEVA_MDL_A_04426360 through 362.
BY MS. RUANE:
Q. This is an e-mail chain between you and Bill Cunningham, correct?
A. Yeah.
Q. Who is Bill Cunningham?
A. My manager.
Q. And what was his title?

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A. Probably director of market access. We had various titles.
Q. It looks like -- did you and Bill office in the same place?
A. Bill was located in California.
Q. It looks like you were e-mailing Bill to discuss a managed care Actiq presentation, correct?
A. Yes.
Q. And so that would be a promotional piece, correct?
A. If I'm presenting it, yes.
Q. You write, in the first line of your e-mail on Page 361 --
A. Yes.
Q. -- Bill, I wanted to follow up with you about the managed care Actiq presentation. I think there's a lot of great information in these slides and I'm sure we can consolidate them to address a managed care audience.
Do you see that?
A. I do.

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Q. So that would indicate that this is a promotional piece that you or your team are going to use to present to a managed care audience, correct?
A. Yep.
Q. And your thoughts on that, you define below.
There are four topics that the slides could be broken into, which you include there as defining pain, economic impact of pain, pain management and Actiq, correct?
A. Yep.
Q. And you indicate, The story should be built around the objective of explaining why providers want to or should have access to Actiq.
Do you see that?
A. Yep.
Q. And this is an e-mail that you drafted, correct?
A. Yep.
Q. And so your plan was to provide a slide set promoting the use of

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Actiq by providers, correct?
That's a bad question. Let me ask it differently.
You were speaking to managed care entities who are evaluating the prescriptions for Actiq that prescribers out in the field are prescribing, correct, to determine whether they will be authorized and reimbursed?
A. Under prior authorization, is that -- we talked before about formulary access versus prior authorization.
So what is your question?
Q. Let me ask first, you're presenting, at this time, to managed care entities in order to educate them about Actiq and why providers, healthcare providers, either want to or should have access to Actiq, correct?
A. For their patients, correct.
Q. For their patients.
And so there may be a couple of things that happen as a result of

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that, if things go your way.
One of them would be that the managed care entity expands the criteria that they would use in order to authorize use of Actiq?
MS. HILLYER: Objection to form.
THE WITNESS: You're implying that the Actiq coverage was not broad. You're making a broad statement. Each plan had different coverage criteria.
BY MS. RUANE:
Q. Were there plans who had coverage criteria just for breakthrough cancer pain?
A. Yes.
Q. And one of things that you were doing, when you were promoting Actiq to the managed care entities, particularly those whose indication was for breakthrough cancer pain, was an attempt to educate them to expand beyond breakthrough cancer pain, correct?

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MS. HILLYER: Objection to form.
THE WITNESS: It was to educate them on pain and -- it was, basically, again, talking about pain management.
BY MS. RUANE:
Q. Okay. And you were educating them on pain well beyond breakthrough cancer pain, correct?
A. General pain information, pain management.
Q. And so the answer to my question would be, yes, you were educating them on pain beyond breakthrough cancer pain, correct?
A. Correct.
Q. In this slide set in particular that you're proposing, you start with the overall economic impact of pain --
A. Yep.
Q. -- setting the stage.
And then you move to, What

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does pain look like, correct?
A. Yep.
Q. And you paint the picture, pain is pain, correct?
A. Yes, I do.
Q. And so you were using the phrase "pain is pain," while promoting Actiq to managed care entities, correct?
MS. HILLYER: Objection to form. Mischaracterizes the document.
THE WITNESS: That is not what that says.
BY MS. RUANE:
Q. Your proposal for the slides to be used in the promotion of Actiq to managed care entities included the phrase "pain is pain," correct?
MS. HILLYER: Objection to form. Same objection.
THE WITNESS: This is a recommendation on building a slide set. There's nothing in this document that said anyone would

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say "pain is pain."
BY MS. RUANE:
Q. But you're -- in referencing what your goal was for what the slide set would convey to managed care entities, you define it as painting the picture-pain is pain, correct?
A. Based on this document, that's what it says, yes.
Q. And you include in there various types of pain, acute, chronic and breakthrough, correct?
A. Yes.
Q. And that is not limited to breakthrough cancer pain, is it?
A. No.
Q. You also reference there BTP.
That references breakthrough pain, right?
A. Yes.
Q. And BTCP references breakthrough cancer pain, correct?
A. Yes.

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Q. So there is a distinction between the two acronyms, BTP and BTCP, right?
A. Yes.
Q. The C stands for cancer?
A. Correct.
Q. And within the company, it was understood that BTP meant breakthrough pain and BTCP meant breakthrough cancer pain, correct?
MS. HILLYER: Objection. Objection to form.
BY MS. RUANE:
Q. In your experience with the company, you would use the phrase BTP to reference breakthrough pain and BTCP to reference breakthrough cancer pain, correct?
MS. HILLYER: Objection to form.
THE WITNESS: BTP, we often -- in this situation, this shows the two, but oftentimes we got a little lazy with the BTP,

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breakthrough pain. And it didn't suggest that it wasn't -- if it was referencing the product, it didn't suggest that it wasn't relevant to the indication.
BY MS. RUANE:
Q. Here --
A. Here.
Q. -- you make the point of distinguishing between BTP, which you use to define breakthrough pain, and BTCP, which you use to define breakthrough cancer pain, correct?
A. Yes, that's what I stated.
Q. I'm sorry. Do you need to take a break?
A. No, I was a little worried about this getting caught. Sorry.
Q. You indicate, Show studies for each - conclusion, pain is pain, not treating underlying condition.
Correct?
A. Yep, that's what it says.
Q. The message that you wanted

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to convey with this managed care Actiq presentation was the conclusion that pain is pain, regardless of the underlying condition, correct?
A. What this states is we don't treat the underlying condition. We're not treating the underlying condition.
Q. But the conclusion is pain is pain, correct?
A. Yes, that's what it says.
Q. Because whether -- what you're suggesting there is you show studies for each to indicate that whether you're treating breakthrough cancer pain or another type of pain, what you're treating is the pain itself, correct?
A. Treating pain, correct.
Q. And that is a discussion of the use of Actiq for something other than breakthrough cancer pain, correct?
MS. HILLYER: Objection to the form. Mischaracterizes the document.
THE WITNESS: Why don't you

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state it a different way?
BY MS. RUANE:
Q. Sure.
The title that's in bold and underlined there, Why Providers Want to (Or Should) Have Access to Actiq, did I read that correctly?
A. Yes, you did.
Q. So what we're talking about with this document that you also referred to as a managed care Actiq presentation is a presentation on the drug Actiq, correct?
A. Correct.
Q. And one of the bullet points below that talks about the use of studies to be included to reach the conclusion, pain is pain --
A. I see that, yep.
Q. -- correct?
A. That's what it says, yes.
Q. And so the proposal here is for a promotional document to be used in managed care presentations discussing the

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use of Actiq for something other than breakthrough cancer pain, correct?
A. Based on --
MS. HILLYER: Object to the form.
BY MS. RUANE:
Q. That's a correct statement?
A. Based on what I'm reading. I have no recollection as to whether we actually put this deck together. Maybe you have a copy of it.
It may not have -- it may not have ended up going through our approval process in this format. So I don't know.
Q. So my question is a little different, just based on this document.
A. Sure.
Q. And I understand the distinction. I appreciate that.
A. Okay.
Q. What you were proposing, on October 15th, 2004, was a managed care Actiq presentation to promote the use of

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Actiq for something other than breakthrough cancer pain, utilizing the phrase "pain is pain," correct?
A. I want to make a distinction between promote -- health plans do not prescribe medications. This was at a time in which, early on, Actiq was not managed by plans, often it was just available.
There was a trend to move towards managing -- and when I say "manage," I'm talking about what we said earlier, prior authorizations and criteria.
As a result of this, many patients who doctors deemed appropriate were on medications such as Actiq for what they deemed appropriate, whether it be noncancer pain, and that's their prerogative.
So this was an effort, albeit looking at it now, I don't know if it ever made it to fruition, to establish what the plan is, again, keeping in mind,

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plans were not experts on pain management. The majority of products available for pain management were generics, and plans don't pay a whole lot of attention until branded products are available.
And with Actiq, it was highly managed across the board, it evolved into that situation. Ultimately, with Fentora it was the same way.
Q. So with this presentation, your proposal was to present to managed care entities advocating or explaining why providers want to or should have access to Actiq for something other than breakthrough cancer pain, correct?
MS. HILLYER: Objection to form.
THE WITNESS: I prefer the word "explaining."
BY MS. RUANE:
Q. Then let me ask it again.
The managed care Actiq presentation that you were describing

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here was a proposal to explain to managed care entities why providers want to or should have access to Actiq for something other than breakthrough cancer pain, correct?
A. That's what it states.
Q. You agree? That's a correct statement?
A. That's exactly what it says.
Q. Okay.
MS. RUANE: All right. Let's take a quick break.
VIDEO TECHNICIAN: Going off the record. 11:39 a.m.
- - -
(Whereupon, a brief recess was taken.)
- - -
VIDEO TECHNICIAN: We're back on record at 11:51 a.m.
BY MS. RUANE:
Q. I'm going to hand you Exhibit-10.
- - -

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(Whereupon, Teva-Bearer Exhibit-10, TEVA_MDL_A_10105779-782, was marked for identification.)

- - -

MS. RUANE: For the record, this is TEVA_MDL_A_10105779 through 782.

MS. HILLYER: Are they different --

MS. RUANE: Those are -- I'm sorry. And then -- so the native -- if you look at 782, it's the native attachment for the sheets behind that. They are the exhibits -- or the attachments to the e-mail. Does that make sense?

MS. HILLYER: Yes.

MS. RUANE: Okay.

THE WITNESS: Okay.

BY MS. RUANE:

Q. This is quick.

This is an e-mail showing that all the NAMs should receive a copy

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of the Actiq MCO dossier.

Do you see that?

A. Yes.

Q. What are NAMs?

A. National account managers.

Q. And at that point, you were a national account manager, in 2006?

A. No.

Q. No, you weren't.

A. I was a manager.

Q. Got it.

You'll see on the attachments, just to the extent it's helpful to you --

A. Yes.

Q. -- you're listed on both of them.

Those are the attachments for the individuals who should receive a copy of the Actiq dossier.

Do you see that?

MS. HILLYER: Objection to form.

THE WITNESS: Yes.

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MS. HILLYER: Go ahead.

THE WITNESS: I'm sorry, you're asking me to look at the list -- the roster?

BY MS. RUANE:

Q. You see your name is on the list of people to receive an Actiq dossier?

A. Yes.

Q. On the second page, 780, the last sentence of the first paragraph --

MS. HILLYER: Take your time to look through it, if you need to.

BY MS. RUANE:

Q. -- indicates, There have been some updates to the Provigil white paper and we have arranged for all the NAMs to receive copies of the Provigil and Actiq white paper.

Do you see that?

A. Yes.

Q. So let me hand you Exhibit-11.

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- - -

(Whereupon, Teva-Bearer Exhibit-11, TEVA_CHI_00036903-930, was marked for identification.)

- - -

MS. HILLYER: Are we done with 10?

MS. RUANE: I think so.

For the record, this is TEVA_CHI_00036903 through 930.

BY MS. RUANE:

Q. This is an Actiq managed care dossier, correct?

A. Yes.

Q. Are you familiar with this type of document?

A. Yes.

Q. These are documents provided to managed care entities?

A. Upon request of medical services.

Q. If a managed care entity requested information about Actiq, it would -- this managed care dossier would

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be provided to them, correct?
A. Through medical services, correct.
Q. I assume that there were times where managed care entities would request, through medical services, a copy of the dossier, which is why it was created?
A. Correct.
Q. This was the Actiq dossier, correct?
A. That's what it says, yes.
Q. And I'll tell you, there's three modules, they are divided up.
A. I haven't seen this in years, so I'm glad you told me that.
Q. You would have seen it at the time, correct?
A. If it was sent to me, I saw it, yes.
Q. And in your interactions with managed care entities during this time frame, you would have spoken with them about the dossier, if they had

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requested it, correct?
MS. HILLYER: Objection to form. Assuming facts not in evidence.
THE WITNESS: No. No. They would have -- if they asked for a dossier, we would send in a request to medical services, period. That's all you can say. You're not allowed to discuss what's in the dossier. It's not a promotional piece.
BY MS. RUANE:
Q. I'm sorry, what did you say about promotional piece?
A. This is not a promotional piece. This is a medical piece.
Q. And in this document, on the second page -- there's little page numbers at the bottom, I'm going to use those, just for ease of reference.
A. I see. And what page did you say? I'm sorry.
Q. 2.

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A. 2, got it.
Q. This document indicates, in that last paragraph, Breakthrough pain, defined as a transitory flare of moderate-to-severe pain that occurs in patients with otherwise stable, controlled, persistent pain, is a prevalent form of pain in patients with malignant and nonmalignant diseases.
Do you see that?
A. Yes.
Q. I'm looking back at 7.
MS. HILLYER: Do you want her to?
MS. RUANE: Yes.
BY MS. RUANE:
Q. If you'll pull up Exhibit-7 as well.
MS. HILLYER: Give me a second, please.
Okay, we're there.
BY MS. RUANE:
Q. Exhibit-7 was an e-mail chain regarding feedback on the Actiq

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white paper.
Do you see that?
A. Yes.
Q. And the suggestion, under Module 1, which we're looking at Module 1, right?
A. So based on what I'm seeing here today, these are two different -- two different pieces.
This is a dossier. This is a white paper.
Q. Okay. That's -- I'm going to ask you --
A. As I recall. I mean, we would not call a dossier a white paper.
Q. So I want to make sure I'm clear on something as it relates to that.
On Number 2, this Actiq white paper feedback e-mail --
A. Yes.
Q. -- if you look at Number 2D, the revision that they ended up with --
A. Right.
Q. -- indicates -- and we're

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looking at Exhibit-7 right now, so we're talking about the white paper, right?
A. Yes.
Q. And it indicates, Breakthrough pain, defined as a transient flare in pain of moderate-to-severe intensity occurring in conjunction with persistent pain, is a prevalent form of pain in patients with malignant and nonmalignant diseases.
Correct?
A. That's what it says.
Q. Okay. And that's the same language that's included in the dossier, correct?
MS. HILLYER: Objection to form. It's not. I mean, it's not.
BY MS. RUANE:
Q. With the exception of "transitory" to "transient"?
MS. HILLYER: There's some different wording, but --
BY MS. RUANE:

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Q. Let's look just at the part that references, Patients with malignant and nonmalignant diseases.
The phrase "patients with malignant and nonmalignant diseases" appears in both Exhibit-7 and 11, correct?
A. It's unfortunate -- correct. It's unfortunate these aren't referenced, because in many documents you'll have inconsistent approaches to the way -- I mean, in anything, as long as it's sourced.
This is a very old dossier layout. Currently, you have to annotate the entire thing and then you have actual, you know, verbatim. So this was sort of in the beginning. This is not the traditional format that is used today. So I will just say that part.
So it wouldn't be uncommon for one document to have -- as long -- because definition can come from one source but reads differently than

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another. So I can't really comment.
Q. But what we do know, because we have the documents before us, is that the Exhibit-11, the dossier, references breakthrough pain as a prevalent form of pain in patients with malignant and nonmalignant diseases, correct?
A. Yes.
Q. And based on Exhibit-7, we also know that, at least the feedback for the Actiq white paper, and the conclusion that Susan, in medical services, reached was to reference breakthrough pain as a prevalent form of pain in patients with malignant and nonmalignant diseases, correct?
A. Yes.
Q. Okay. Just a few more questions on Exhibit-11.
On Page 10 of Exhibit-11, the second -- or, I guess, the first full paragraph starts, For many patients.
Do you see that?
A. I do see that.

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Q. And the first sentence there says, For many patients, no causative factor can be found for the chronic pain and no specific diagnosis can be made.
Do you see that?
A. Yes.
Q. Do you agree that is not referencing breakthrough cancer pain, correct?
A. It does not mention breakthrough cancer pain.
Q. It mentions chronic pain with no causative factor found, correct?
A. Correct.
Q. If you go on in the middle of the paragraph, there's a sentence that starts, However, experts in pain management have recommended that the primary goal of patient care for these patients should be symptom control, including the use of opioids where appropriate.
Do you see that?
A. Yes.

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Q. And then the next -- there's citations.
So there were some cites in this white paper?
A. I see that. I see that.
Q. In the dossier, excuse me.
A. Yeah. Good.
Q. And then it references, Several professional organizations have published guidelines to guide practitioners in this area.
Do you see that?
A. I see that.
Q. And it references specifically the American Academy of Pain Medicine, the American Pain Society, and the Federation of State Medical Boards of the United States.
Do you see that?
A. I see that.
Q. So based on Exhibit-11, we know that Cephalon, in its dossier, was referring back to societies, at least as part of the support for the proposition

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that patients with no causative factor for their chronic pain should be treated with opioids?
MS. HILLYER: Objection to form. Mischaracterizes the document.
THE WITNESS: You'll have to restate that. I don't agree with what you just said.
BY MS. RUANE:
Q. We know that Cephalon was using a dossier and published a dossier that discussed opioid treatment for patients with chronic pain where no specific diagnosis can be made, correct?
MS. HILLYER: Objection to form.
You can answer.
THE WITNESS: So I didn't create this document. But what I will tell you is, for the record, patients who are prescribed a -- either Fentora or Actiq, were -- had chronic pain, they were on

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chronic pain medications, which sometimes included opioids. So this is all true.
This is more about chronic pain and then, hopefully, it will get to start talking about breakthrough pain.
But these are chronic pain patients who have been on a long-acting OxyContin, something of that nature, and they have breakthrough episodes of which the short-actings are appropriate.
So, to me, this is just setting the stage in general, in my interpretation.
BY MS. RUANE:
Q. And it is referring to patients who have that chronic pain but do not have cancer, correct?
A. It's a general statement about pain.
Q. Yes.
But the beginning paragraph

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discusses the fact that these are patients where no causative factor can be found for their chronic pain and no specific diagnosis can be made, correct?
A. That's what it states.
THE WITNESS: Are we finished with this one?
MS. RUANE: Yes.
I'm going to hand you what's been marked as Exhibit-12. This is Module 2 for the Actiq managed care dossier.
- - -
(Whereupon, Teva-Bearer Exhibit-12, TEVA_CHI_00036931-955, was marked for identification.)
- - -
BY MS. RUANE:
Q. And I want to make sure I understand this right.
Your testimony is, aside from reaching out to medical services to request a dossier, if that conversation was initiated by a managed care entity,

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you and your team did not discuss the dossiers with the managed care entities; is that correct?
A. That's correct. To my recollection, as far as the dissemination.
I will say I may -- I recall at one point, I don't recall if it was for Actiq or other products, before they became electronic, which is the norm now, they were hard copies, and they were shrinkwrapped, and we were not able to even open them.
And there may have been a vehicle in which an account manager, based on the shrinkwrap, could deliver it. I vaguely -- I do remember that.
I don't recall what product it was, though.
Q. Okay. But it would have been -- based on your training and time with the company, it would have been inappropriate for an individual to speak to the managed care entities about the

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information in the dossier?
MS. HILLYER: Objection to form.
THE WITNESS: That -- no, there may be information in the dossier which would be part of what we would discuss, not specific to the dossier. So I don't think that's accurate.
BY MS. RUANE:
Q. With that distinction. Obviously, the dossier covers a lot of things.
A. Exactly.
Q. But as far as talking specifically about the dossier and the information in the dossier in front of, you know, the managed care entity, it would have been inappropriate for you or your team to discuss the details of that dossier specifically?
MS. HILLYER: Objection to form.
THE WITNESS: Are you asking

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about the content?
BY MS. RUANE:
Q. Yes.
A. Are you asking what is -- if the payer says, what is included, there are several sections? We would say, well, there's economic information, there's background information. Generally like that.
Q. I'm asking whether, based on your earlier testimony that white papers are one thing but dossiers are another, dossiers go through medical services and you would not have spoken with managed care entities about information in the dossier.
Am I -- I want to make sure I understand you correctly.
A. Yes, that is the policy --
MS. HILLYER: Objection. Mischaracterizes the testimony. And objection to form.
You can answer.
THE WITNESS: Sorry.

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As I recall -- mind you, this is a long time ago and we've changed, evolved with the dossier.
Based on my recollection, we would not have discussed the contents of the dossier. That's my recollection, we would not have.
BY MS. RUANE:
Q. Do you have an understanding of why that was the policy?
A. This is not a medical/legal review document.
Q. And what do you mean by that?
A. It's not a promotional piece.
Q. The only documents -- am I correct that the only documents your team was allowed to discuss with the managed care entities were promotional pieces?
A. That's correct.
Q. And am I correct that the promotional pieces would have been

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approved by medical/legal?
A. Yes. Although I'm not remembering about the WL lefts, the reprints that may have been part of that back in those days.
Obviously, policies have changed over time. So I don't recall if there were any clinical reprints that were approved for dissemination.
Q. Okay. And I appreciate that. If we get there, we get there; if not, no big deal.
But what I want to make sure I understand is, when you talk about the promotional piece, it appears to have some significance, the phrase "promotional piece." And so I want to make sure I understand what that means to you.
It sounds like what it means to you is a piece that has been approved by medical/legal that you can discuss with the managed care entities; is that correct?

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A. Medical, legal, and regulatory.
Q. Okay. And your memory is the Actiq white paper, which I know is different in your memory than what we're looking at right now, but your memory is the Actiq white paper was a promotional piece?
MS. HILLYER: Objection. Mischaracterizes testimony.
THE WITNESS: No.
BY MS. RUANE:
Q. So the Actiq white paper is not a promotional piece?
A. My memory is based on the e-mail you showed me, which shows professional services.
And without specifically remembering the details of the white paper, anything that referenced professional services fell under a nonpromotional piece that was disseminated upon request.
Q. Let's look at -- I gave you

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Exhibit-12, right? Module 2.
MS. HILLYER: No.
I don't think you put it on the record, if you wanted to.
MS. RUANE: Sorry. Thank you.
BY MS. RUANE:
Q. We're now looking at Exhibit-12, which is TEVA_CHI_00036931.
Again, there's little numbers on the document, I'm just going to use those because it's easier.
A. I see.
Q. On Page 3 of the document, the last paragraph, about halfway through, there's a sentence that starts with, Addiction?
A. Yes.
Q. It says, Addiction, a disease characterized by behaviors such as compulsion, harm to the user or continued use despite harm, is uncommon in patients using opioids for a medical condition.

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Do you see that?
A. I see that.
Q. What scientific support is there for that statement?
MS. HILLYER: Objection. Lack of foundation. Calls for speculation.
BY MS. RUANE:
Q. Do you see any there?
A. I can't answer that question.
Q. You had mentioned earlier that sometimes there's citations to the studies supporting statements.
Do you see any citation there or reference point?
A. Nope.
Q. Do you know, just based on your personal experience in managed care with opioids over time, any -- do you have any support, any scientific support, that you're aware of for that statement?
MS. HILLYER: Objection. Calls for speculation. Lack of

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foundation.
THE WITNESS: I don't have an opinion about that.
BY MS. RUANE:
Q. Do you believe that addiction is uncommon in patients using opioids for medical conditions?
MS. HILLYER: Objection to form.
THE WITNESS: I'm not a physician.
BY MS. RUANE:
Q. You have no opinion one way or another?
A. No.
Q. Page 22 references pseudoaddiction.
Do you see that?
A. Yes, I do.
Q. Are you familiar with the term "pseudoaddiction"?
A. I don't recall.
Q. You agree it's a term that was used in documents provided by the

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company?
MS. HILLYER: Objection to form.
THE WITNESS: I don't remember seeing pseudoaddiction in any of the pieces that we used with payers.
It may have been, I just don't recall.
BY MS. RUANE:
Q. Pseudoaddiction is in Exhibit-12, which was provided to managed care payers upon request?
MS. HILLYER: Objection. Assumes facts not in evidence.
BY MS. RUANE:
Q. I mean, you see it in Exhibit-12, right?
A. I said I don't recall because this is the first time I've seen this in how many years.
But your statement is correct. In bold words -- letters, it says, Pseudoaddiction. And it's in a

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module that would have been received by payers.
Q. And pseudoaddiction there states, Addiction should be distinguished from pseudoaddiction, which is characterized by drug-seeking behaviors caused by unrelieved pain. Some patients with unrelieved or untreated pain may be aggressive in requesting additional analgesics. When such requests are not related to psychological beliefs nor to psychic effects, but rather to unrelieved pain, the appropriate response is improved pain management.
Do you see that?
A. I see that.
Q. Do you see any scientific support for that statement?
MS. HILLYER: Objection. Do you mean in the document?
MS. RUANE: In the document.
THE WITNESS: I don't see anything.
BY MS. RUANE:

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Q. Do you know any scientific -- I'm sorry, I didn't mean to interrupt you.
A. I was answering. You just couldn't hear me.
Q. Sorry. Go ahead.
A. I do not see a reference on this document.
Q. Do you know of any scientific support for the theory of pseudoaddiction?
MS. HILLYER: Objection to form.
You can answer.
THE WITNESS: I'm not familiar with this, period.
BY MS. RUANE:
Q. You're not familiar with pseudoaddiction?
A. So I can't answer your question.
Q. Given your role with managed care entities assessing reimbursement issues related to Actiq and then

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Fentora --
A. Sure.
Q. -- did you receive education and training on issues related to addiction or abuse of opioids?
A. Sure. I just don't recall if this is what I stated.
Q. And what type of training and education did you receive?
A. There were training modules that all the account managers were required to complete on the disease state, misuse, abuse, diversion, all the things that we're talking about, as far as what you're referring to here, in addition to the mechanism of action of the product, as with any training on a product that any pharmaceutical company would provide, not unlike that.
Q. And during your time working with managed care entities on the products Actiq and then Fentora, did you come to any conclusions about the issues of abuse associated with those drugs?

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MS. HILLYER: Objection to form.
THE WITNESS: No conclusions.
BY MS. RUANE:
Q. Sitting here today, have you reached a conclusion as to whether there's an opioid epidemic?
MS. HILLYER: Objection to form.
THE WITNESS: A conclusion, no.
BY MS. RUANE:
Q. Page 23 of Exhibit-12 --
A. I'm sorry, you said 23?
Q. Yes, just the next page.
The last sentence in the first paragraph indicates, Similarly, the risk of abuse is low in patients with nonmalignant pain, though there is less experience in this patient population.
Do you see that?
A. I'm sorry, I wasn't following where it is.

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Q. Up at the top.
A. Up at the top, sorry.
Q. And then right below that, under, Managing the risk of opioid abuse, in that first sentence, it indicates, Although it is uncommon for chronic pain patients to abuse opioid medications, there is a potential risk associated with the use of all opioids.
Do you see that?
A. I see that.
Q. Do you know of any scientific -- well, strike that.
First, let me ask you, do you see any scientific support cited in Exhibit-12 for those statements?
A. No.
Q. Do you personally have any scientific support for the idea that it's uncommon for chronic pain patients to abuse opioid medications?
MS. HILLYER: Objection to form.
THE WITNESS: Are you saying

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do I have an opinion?
BY MS. RUANE:
Q. Yes.
A. I don't have an opinion.
Q. This is information that was created by, I guess at this time, by Cephalon, correct?
A. It was -- yes.
Q. And Cephalon was also the company that was creating the modules used to train you all on Actiq, correct?
MS. HILLYER: Objection to form.
THE WITNESS: I was not involved with the sales training. I don't know who developed that.
BY MS. RUANE:
Q. But Cephalon was the -- I mean, you didn't receive training on issues of opioids and potential abuse or diversion from anyone outside the company, correct?
A. I don't -- no. No, I don't recall.

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Q. So it's a correct statement that your training on issues of potential abuse, diversion of opioids would have occurred through your employment with Cephalon and then Teva, correct?
A. That's a true statement.
MS. RUANE: I'm going to hand you what's been marked as Exhibit-13. And for the record, this is TEVA_MDL_A_03272381.
- - -
(Whereupon, Teva-Bearer Exhibit-13, TEVA_MDL_A_03272381-391, was marked for identification.)
- - -
BY MS. RUANE:
Q. This is an e-mail you sent to Terry Terifay regarding an upcoming Actiq speaker training.
A. Yes.
Q. And Page 382, that second page, what you'll see, as you go through it, there's different -- I assume these

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are different managed care entities, right?
You've got Blue Cross and Blue Shield of Alabama and then Regents. And you mentioned there's probably over 100 in the nation, but these are some you all dealt with, correct?
A. Correct.
Q. Under Blue Cross and Blue Shield of Alabama, the description under primary purpose of the clinical presentation, toward the bottom of the page, this is a document that's providing some managed care Medicaid scenarios for an Actiq speaker training, correct?
A. Yes.
Q. And the Actiq speaker training would be a training of -- well, strike that.
Who -- what speakers were being trained?
A. I don't recall.
Q. Are they Cephalon employees or are they the key opinion leaders that

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we discussed earlier, do you know?
A. Speakers -- say the question one more time.
Q. Sure.
The speaker training, would it be for employees of Cephalon who are going to do a managed care presentation?
A. I don't recall.
Q. Under the primary purpose of the clinical presentation, the second bullet point there indicates, Explain different utilities for Actiq and reasons why pain management specialists are prescribing it for noncancer breakthrough pain.
Do you see that?
A. Yes.
Q. And that's something that would happen at these meetings with managed care entities, correct?
MS. HILLYER: Objection to form.
THE WITNESS: This -- the way -- you're asking if this

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presentation was for -- to payers?
Is that what you're -- I'm sorry.
BY MS. RUANE:
Q. Let's back up and make sure we're --
A. Let's make sure we're on the same page.
Q. -- on the same page.
These are managed care Medicaid scenarios --
A. Yes.
Q. -- provided by national account managers --
A. Yes.
Q. -- for the upcoming Actiq speaker training?
A. Yes.
Q. Okay. So this is going to be for a speaker training meeting?
A. Right.
Q. Presumably those speakers, their role is then going to be to go out and talk to managed care entities, correct?

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A. No, I don't interpret it this way.
Q. What would the speaker training be for?
A. Based on what I'm reading here, having -- not recalling this, the --
MS. HILLYER: Then objection. Calls for speculation.
THE WITNESS: Yeah, I really don't know.
BY MS. RUANE:
Q. Let's back up a little bit.
A. Okay.
Q. Look, for example, on Blue Cross and Blue Shield of Alabama, the second heading there is, Key decision-makers who will be attending the clinical presentation.
Do you see that?
A. Yes, I do. Yep. Yep.
Q. Is that helpful?
A. Yes.
Q. So are we now on the same

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page, that this is information provided in advance of meetings with managed care entities?
A. Hold off. Let me look.
That's the way I would interpret this.
Q. And down below, under primary purpose, there's the bullet point for explaining different utilities for Actiq and reasons why pain management specialists are prescribing it for noncancer breakthrough pain, correct?
A. That's what it says.
Q. Okay. And you were aware of this at the time, because these were scenarios that you sent to Terry Terifay, correct?
A. Yes.
Q. The bullet point below that indicates that another purpose of the presentation was to convince the plan to consider coverage for any of the above uses, correct?
A. I'm sorry, where are you

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here?
Q. Sorry. Third bullet point down on primary purpose.
A. Yes, that's what it says. Sorry.
Q. So one of the goals, when you're meeting with these managed care entities, is to convince the plan to consider coverage for any of the above uses, and that's referring to noncancer breakthrough pain uses, correct?
A. That's what it says.
Q. That was one of the goals of you and your team when you were meeting with managed care entities for Actiq and then subsequently for Fentora, correct?
MS. HILLYER: Objection to form.
THE WITNESS: In general. We had different objectives for each plan, depending on the situation, because each plan payer is different.
BY MS. RUANE:

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Q. For Blue Cross and Blue Shield of Alabama --
A. I don't have any direct knowledge of that. That wasn't a part of my area.
That's why I'm hesitating quite a bit, because these are not plans -- I was trying to figure -- that I have direct knowledge of.
Q. And the reason -- I mean, in fairness to you, I understand it was a long time ago, so we'll work through it together.
But you are -- you were the one that sent this e-mail, right?
A. Correct.
Q. And one of the things that you just know, in addition to the e-mail, from your own personal experience is that many times when you were meeting with managed care entities, one of the things you were doing was working to convince them to consider coverage for something other than breakthrough cancer pain,

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correct?
MS. HILLYER: Objection to form.
THE WITNESS: We presented information. As I stated before, many plans -- I don't know the details around these -- did not have a lot of rigor behind Actiq early on.
By the time I joined the company in 2004 was when payers were starting to take a look at opioids. And sometimes by just default they would make decisions on coverage. I can't speak to what specifically they were.
As I mentioned earlier, coverage criteria goes beyond indication. There are many other requirements in coverage criteria.
Additionally, many patients were currently on, as a doctor deemed appropriate, whether it -- whether they -- depending on the

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diagnosis, it was up to the doctor as to what product was appropriate.
So I view this as more of an education, because many times when restrictions come quickly, it causes a disruption for the patient in treatment.
So a lot of this was an education process. Many of these plans we had not engaged with on a regular basis for Actiq.
BY MS. RUANE:
Q. And so the goal was, in those cases, to convince plans to consider coverage for something other than breakthrough cancer pain, correct?
A. The goal is --
MS. HILLYER: Hold on. Objection to form. And asked and answered.
You can answer again.
BY MS. RUANE:
Q. I mean, at least as it

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relates to this Blue Cross and Blue Shield of Alabama.
Let me ask a different question.
You would agree that this document, which you provided to Terry Terifay, indicates that one of the primary purposes of the clinical presentation is to provide -- was to, strike that -- to convince the plan to consider coverage for any of the above uses, which refers to noncancer breakthrough plan?
MS. HILLYER: Objection to the form. Lack of foundation. And calls for speculation. She said she didn't cover this account.
THE WITNESS: I don't have direct knowledge of Blue Cross Blue Shield of Alabama.
BY MS. RUANE:
Q. Let me ask a different question.

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We know, and we talked about in the first hour of this deposition, the fact that you were -- as a national account manager and then subsequently as you became a director, you met with managed care entities, right?
A. Correct.
Q. And one of the things you did, during your time as a national account manager at Cephalon, was to meet with managed care entities, correct?
A. Yes.
MS. HILLYER: Asked and answered.
BY MS. RUANE:
Q. And during that time, one of the products that you would discuss was Actiq, correct?
A. Correct.
Q. And, obviously, it depends on the plan and what their coverage is --
A. Right.
Q. -- at that time, but one of the things that you did was work with

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plans who didn't have the coverage criteria for Actiq that would have been most beneficial for purposes of increased prescriptions, would be to work with those plans on convincing them to consider coverage for something other than breakthrough cancer pain, correct?

MS. HILLYER: Objection to form.

BY MS. RUANE:

Q. That's a thing that happened, isn't it?

MS. HILLYER: Objection to form.

THE WITNESS: A result --

MS. HILLYER: Go ahead.

THE WITNESS: As I stated previously, much of the interaction, whether it be promotional or from medical, was an educational process where many patients, whatever the physician deemed appropriate, prescribed Actiq for their patients.

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Part of what we discussed was the broad spectrum of pain management, et cetera, as you've seen in all of these documents.

If, in fact, they did change criteria, the result would be the patient would have access ultimately at that point, to your point, and Cephalon would have the benefit of the sale of that product. So that's an accurate statement.

BY MS. RUANE:

Q. And it's also an accurate statement that during those times that you were talking to the managed care entities, you were talking to them about the broad spectrum of pain, which included pain beyond breakthrough cancer pain, correct?

MS. HILLYER: Objection to form.

THE WITNESS: Honestly, I don't remember engaging with a

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plan specifically to the question that you've asked me. I really don't recall specifically.

Many times, plans would request information.

BY MS. RUANE:

Q. And based on the fact that you've been with the company, you know, for over a decade -- I understand a lot of this was a long time ago.

But you've just described for us how you would speak to them about the broad spectrum of pain; that was part of the job, was to educate them on the broad spectrum of pain.

And you agree that broad spectrum of pain went beyond breakthrough cancer pain, correct?

MS. HILLYER: Objection to form. It mischaracterizes testimony.

BY MS. RUANE:

Q. That's a correct statement, isn't it?

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MS. HILLYER: I made my objection.

She can answer the question.

THE WITNESS: Again, pain management was not something familiar to payers. If I -- if I had a conversation with a plan, it would have been based on an approved document that may have had the disease background on pain management. Because, again, this is for patients suffering from chronic pain who have breakthrough episodes. So it's very relevant to talk about chronic pain, spectrum of pain, and talk about breakthrough episodes specific to our label, which would then include cancer patients.

BY MS. RUANE:

Q. And the conversation about the chronic pain and the breakthrough pain would not necessarily be limited to cancer patients, correct?

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MS. HILLYER: Objection to form.
THE WITNESS: I don't recall the documents -- maybe you'll provide them to me -- the documents that we used. I honestly don't remember the content of those.
A lot of what we do with payers is educate on disease state, as I've stated before. This is very common in current products that we promote now. It's very common to talk about standard of care. It's very common to talk about chronic and acute medications.
It sets the foundation for the discussion with a payer.
BY MS. RUANE:
Q. Okay. If you look on Exhibit-13, on Page 82 at the bottom, it references several objections from the plan, including the concern over abuse

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and diversion of opioids.
Do you see that?
A. I saw it previously. Is this 82?
Q. 82, yes. At the very bottom.
A. Right. Sorry.
Q. Do you see that?
A. Yep, yep.
Q. On Page 85, the second bullet point indicates, Physicians are afraid of opioid use.
A. You're saying 85?
Q. Yes. 85.
A. Yes.
Q. Do you see that?
A. Yes, that's what it says.
Q. The last two -- well, strike that. Let me ask this first.
Do you recall receiving feedback from managed care entities regarding fears of opioids and abuse as a reason not to expand the criteria?
A. Schedule II products, many

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of them. So, of course, we -- they would discuss any scheduled product.
Q. And so it was -- generally speaking, it was a conversation you would have with these managed care entities, because they would bring up the concerns associated with Schedule II products?
MS. HILLYER: Objection to form.
THE WITNESS: Not -- you're making a broad statement, and I can't speak to every conversation that I had with every plan.
Misuse, abuse and diversion, we take a responsibility as a company, we are certainly aware of that.
So if they asked the question, we would have a conversation about it.
BY MS. RUANE:
Q. And as a company, misuse, abuse and diversion are things that the company was aware of and you were aware

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of, correct?
MS. HILLYER: Objection. Calls for speculation.
THE WITNESS: We're aware of because it's a Schedule II product.
BY MS. RUANE:
Q. And because of that fact, you found yourself speaking to managed care entities about their questions associated with a Schedule II product and use, abuse and diversion, correct?
A. I don't recall any specific questions around -- I just don't recall any specific questions that I received and having that conversation.
Q. But you would agree that they did occur, at least sometimes, because we've looked at a couple of them in this document, correct?
MS. HILLYER: Objection. Calls for speculation. Lack of foundation.
THE WITNESS: You do realize

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I did not create this document?
This was a compilation of what was sent to me, and I forwarded it on to marketing, it appears.
BY MS. RUANE:
Q. It was provided by the national account managers, right?
A. Yes, yes. I didn't write the document.
So when you're asking me specifics around each of these plans, I don't have the context to answer the question.
Q. But at least what we know from Exhibit-13 is that the national account managers were reporting conversations regarding questions on use and abuse of opioids?
MS. HILLYER: Objection. Calls for speculation.
BY MS. RUANE:
Q. I mean, would you agree? We just looked at this.

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A. Based on this, I would also agree that there are other opioids on the market. It was a general opioids statement. Because it's a Schedule II, it's logical to have that -- that's why it's a Schedule II.
Q. Okay. I'm going to hand you what's been marked as Exhibit-14.
- - -
(Whereupon, Teva-Bearer Exhibit-14, TEVA_MDL_A_04481825, was marked for identification.)
- - -
MS. RUANE: It's TEVA_MDL_A_04481825.
BY MS. RUANE:
Q. This is an e-mail from Robert Host to you.
Do you see that?
A. Yes.
Q. He references a Dr. Guarino, who is a physician in St. Louis who just presented a poster study at a recent pain meeting on nonmalignant pain for Actiq.

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Do you see that?
A. I see that.
Q. Nonmalignant pain is pain that is not related to cancer, correct?
A. That's correct.
Q. Speaking with Amy Jordheim, the MDM.
Who is Amy Jordheim? What does MDM refer to?
A. I don't remember the acronym now, but it's basically an MSL. I just don't know what they --
Q. Now I have to ask what an MSL is?
A. Medical science liaison. So they fall under the medical side. They deal with KOLs, thought leaders. They're medical, not sales.
Q. Got it.
So she thinks, He -- referring to Dr. Guarino -- would be an -- would be excellent to speak to health plans. And the fact that he has actually completed a study for Actiq in

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nonmalignant pain might be beneficial for other speakers to hear him at our meeting in January.
Did I read that correctly?
A. Yes, you did.
Q. Okay. So you were aware of the use of Actiq by speakers who are physicians? We've spoken about that before, right?
A. Correct.
Q. Would Dr. Guarino be the type that we talked about before as a key opinion leader?
MS. HILLYER: Objection to the form.
THE WITNESS: I don't know this.
BY MS. RUANE:
Q. Because he was published on the use of Actiq in something other than -- in something beyond breakthrough cancer pain, it was thought he might be beneficial for other speakers to hear?
MS. HILLYER: Objection.

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Calls for speculation.
THE WITNESS: I don't know.
BY MS. RUANE:
Q. I mean, I'm just reading from what you wrote here.
Because he's actually completed a study for Actiq in nonmalignant pain, it might be beneficial for other speakers to hear him at our meeting in January.
Do you see that?
MS. HILLYER: Objection to form. She didn't write this.
BY MS. RUANE:
Q. Oh, I see. You received it. My apologies.
Robert wrote to you --
A. Yes.
Q. -- indicating that that might be beneficial, correct?
A. Yes.
Q. What meeting in January is Robb referring to, if you know?
A. I don't recall.

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Q. I'll tell you, the subject up above indicates, Dr. Guarino for Actiq managed care training.
A. Oh, yeah, it does say that.
Q. So would that have been a meeting for managed care training?
MS. HILLYER: Objection. Calls for speculation.
THE WITNESS: I don't know.
BY MS. RUANE:
Q. Is it reasonable to assume, since the subject is Dr. Guarino for Actiq managed care training, that the meeting that's discussed would be a managed care training meeting?
MS. HILLYER: Objection. Calls for speculation.
THE WITNESS: That's what it states.
BY MS. RUANE:
Q. Do you know whether -- well, strike that.
Who is Robert Host?
A. A national account manager.

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Q. And at this time, you were also a national account manager?
A. Yes, I believe so, based on the date. Yes.
Q. Did you have a management role over Robert Host?
A. No, I really don't recall.
But they're asking me to speak to marketing. So there was a point where I was in management and still had a home office, sort of liaise responsibilities.
But that's perhaps why I received this. That's a speculation. So I don't know for sure.
Q. And when you say they're asking you to speak to marketing, you're referring to his request that you check with Terry --
A. Yes.
Q. Okay.
Is this a suggestion from Robert Host that Guarino should be utilized to promote the off-label use of

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Actiq?
MS. HILLYER: Objection to form.
THE WITNESS: I can't -- I can't speculate as to what Robert's intention was.
BY MS. RUANE:
Q. But you do agree that the study he completed would be for off-label use of Actiq, correct?
A. It states that he did a study on nonmalignant pain.
We often were requested to bring in speakers, as I mentioned, to educate the plan. If the plan wanted to understand why the prescribers are prescribing Actiq, a request such as this could come in, and we would, if a -- particularly if they've published something or have done a study, there's much more credibility, if the plan -- these are clinical pharmacists.
They may have a need to understand the data associated with

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nonmalignant pain and Actiq. So it's very reasonable that you would have someone that has done a study to give that presentation --

Q. And the data --

A. -- upon request.

Q. And the data associated with nonmalignant pain, it would be data associated with off-label use of Actiq, correct?

A. Clinical studies can be done for any reason.

But based on what I -- a physician makes a determination on how they want to study the product. So based on what I'm reading here, this physician, who I don't know, had a poster which suggests that he did a clinical presentation -- a clinical trial of some sort on nonmalignant pain, which is, again, outside the current -- outside that current label.

Q. Yes, outside the indication, so off label, correct?

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A. It's not in the current indication, yes.

Q. And I just want to be sure we're on the same page.

If it's outside the current indication -- inside the current indication is on label?

A. Yes.

Q. Outside the current indication is off label, right?

A. That's correct, yes.

Q. Okay.

THE WITNESS: We're finished with this?

MS. RUANE: Let's take a quick --

MS. HILLYER: It's almost an hour. We're at 58.

MS. RUANE: That's perfect. Let's do lunch.

VIDEO TECHNICIAN: Going off the record. 12:45 p.m.

- - -

(Whereupon, a luncheon recess was taken.)

- - -

VIDEO TECHNICIAN: Back on record at 1:28 p.m.

BY MS. RUANE:

Q. We're back on the record after a lunch break.

Do you understand you're still under oath?

A. Yes.

Q. Let me ask you, what promotional activities did you perform with regard to managed care for Actiq?

A. In engaging with the payers, we would have approved materials. In fact, I think we often used sales materials because we didn't have a managed care marker, like I am presenting -- putting together specifics. And there was a presentation, as I recall.

Q. And I apologize, I'm going to repeat some of that to make sure I heard you okay. All right?

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So one of the things you mentioned were actually using the sales materials that the sales force used?

A. We may have. There wasn't a managed care marketing department back in those days, which is what I do now. Therefore, managed care-specific pieces were somewhat limited.

Q. Because the managed care team was kind of selling to the managed care entities, while the sales team was out with providers, correct?

MS. HILLYER: Objection to form.

THE WITNESS: Managed care -- the account managers would present to payers if there was an approved document, which, of course, the sales force had approved documents.

It's my recollection that, in certain situations, we would use promotional materials that were approved for HCPs in general.

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BY MS. RUANE:
Q. And what promotional -- do you remember the names or types of promotional materials?
A. Honestly, I do not.
Q. You also mentioned a presentation?
A. I believe there was a presentation. I know we were -- I think there was a point where we were asking for input around promotional presentation. Because the audience is different with payers, oftentimes the information may be different.
I honestly don't recall presenting it, if it was, in fact, approved.
Q. And would that have been kind of -- is your memory of it a slide deck-type presentation?
A. It would be, yes.
Q. Do you have a memory of the name that that type of promotional presentation was given?

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A. No.
Q. What promotional -- well, strike that.
Before I ask, are there any other promotional activities, as it relates to Actiq, that you can recall?
A. With which audience?
Q. With the managed care entities.
A. Not that I can recall.
Q. Were there other audiences that you were involved in providing promotional activities with regard to Actiq on?
A. Not that I recall.
Q. What promotional activities did you perform with regard to managed care for Fentora?
A. Similar -- similarly, there was a managed care presentation from a promotional -- that would have to go through our medical/legal, you know.
I believe when we launched Fentora, I was transitioning to the other

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position. So, again, I don't recall how much interfacing, customer-facing, with Fentora, I personally had.
Q. Okay. And so that managed care presentation would be a slide deck as well?
A. Yes.
Q. Were there sales materials used in the promotion of Fentora to managed care entities?
A. I don't -- I don't recall. Unlikely.
Q. Was that because at that point the managed care department had its own marketing?
A. Yes. So we had payer-specific information.
Q. So the payer-specific managed care marketing information for Fentora would have been derived in the managed care -- created within the managed care system?
A. Correct. No. Created in the managed care system?

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Q. On the managed care team. Somebody in the -- was there a marketing person within the managed care team?
A. No -- well, until they moved toward that. But at that point, if memory serves, typically, the -- there was a marketing brand team member who had responsibility for the payer piece to it.
Q. Got it.
And do you recall who the marketing brand team payer -- strike that. Let me start over.
Do you recall who the marketing brand team member who was assigned to managed care was?
A. I believe it was Matt Falker.
Q. How do you spell that last name?
A. F, as in Frank, A-L, as in live, K-E-R.
Q. Did you -- backing up.
Did you have a hand in the creation of the promotional materials

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used for Actiq?
A. No.
Q. Did you have a hand in the creation of the promotional materials used for Fentora?
MS. HILLYER: Objection.
THE WITNESS: For the payer?
BY MS. RUANE:
Q. Payer, yes.
A. Yes.
Could you define "hand," though? What do you mean?
Q. Did you provide content or comments?
A. Comments.
Q. And those promotional materials would be presented to managed care entities and discussed with managed care entities, correct?
A. Yes. Promotional materials are presented to payers, managed care.
MS. RUANE: I'm going to hand you what's been marked as Exhibit-15.

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- - -
(Whereupon, Teva-Bearer Exhibit-15, TEVA_MDL_A_09457158-159, was marked for identification.)
- - -
MS. RUANE: The document number is TEVA_MDL_A_09457158.
BY MS. RUANE:
Q. This was an e-mail to you. And the subject is, Fentora MCO slides.
Do you see that?
A. Yes, I do.
Q. What is MCO?
A. Managed care organization.
Q. So would these be Fentora slides for the managed care entities?
A. I'm going to look at it, but based on the -- yes.
MS. HILLYER: Take your time.
You've got two files attached, it looks like, but only one native Bates file attachment.

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MS. RUANE: Let's see.
MS. HILLYER: I have these two here, right?
MS. RUANE: Right. Let's look at this.
MS. HILLYER: Are they all part of one Bates?
MS. RUANE: They are all -- the Bates numbers are in order.
MS. HILLYER: Right. I have the e-mail and one native file attachment. So it looks like I have two native file attachments.
MS. RUANE: I see what you're saying. The second native file attachment, Bates order-wise, we go from 19457159 to 09457160.
MS. HILLYER: I don't have 60 here.
MS. RUANE: If you go -- do you not have that page?
MS. HILLYER: Yes. That's why I wanted to make sure. I don't think I do.

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MS. RUANE: That's a printing issue on our end.
MS. HILLYER: All right. So we're going to make it -- I don't know if this copy does, then, either. I just want to make sure it's all -- that we keep track of everything.
MS. RUANE: No, I appreciate it. And I can explain it for the record as well and get you that native page.
MS. HILLYER: She also doesn't have 60.
MS. RUANE: Then let me explain for the record what it is, just so that when we're looking back later.
Thanks for clarifying that, Becca.
BY MS. RUANE:
Q. So what you have before you is Exhibit-18. And there is the native page for the document entitled, Chronic

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Pain, the Breakthrough Pain Component, 09457159.

The Bates number for the managed care presentation is 09451760.

MS. HILLYER: That's the draft for review?

MS. RUANE: The draft for review. That's correct.

BY MS. RUANE:

Q. So let me ask you --

MS. HILLYER: Sorry, I don't mean to be picky. But the e-mail only has one attachment, as far as I can tell.

MS. RUANE: And that's where --

MS. HILLYER: So I just want to make sure these really belong together.

MS. RUANE: I understand. I understand the concern.

All I can tell you is -- the managed care speaker deck -- I mean, we can go -- the thing that

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I'll say about it is if you look at the 7158, and then chronic pain is 7159, managed care is --

MS. HILLYER: Not referenced on the title.

MS. RUANE: Okay. All right. Let's do this. Take out managed care. I don't want to confuse it. We'll deal with that separately.

THE WITNESS: Okay.

MS. HILLYER: Okay.

MS. RUANE: All right.

MS. HILLYER: So what we have here that says, Chronic Pain, the Breakthrough Pain Component --

MS. RUANE: Yes.

MS. HILLYER: -- that, you're saying, is what is referred to as attachment, Managed Care Speaker Deck Version 2.1 --

MS. RUANE: What I actually think is the speaker deck includes both of them, but I understand

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that it looks like there's one attachment. I think it's a PowerPoint. I don't understand why there would be two native images, but they line up in order.

MS. HILLYER: But what are the Bates -- are there two Bates?

MS. RUANE: There's two Bates.

MS. HILLYER: So it could just be a different native file than what was attached.

MS. RUANE: Correct. So that's why, let's just leave it on its own and we can deal with it --

MS. HILLYER: So Chronic Pain, the Breakthrough Pain Component is TEVA_MDL_A_09457159.

MS. RUANE: Yes. Correct.

MS. HILLYER: So what we have as Exhibit-15, then, is 7158 through 7159?

MS. RUANE: Yes.

MS. HILLYER: We're going to

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set this one aside. We're going to focus this on the side and focus on those two, the cover e-mail and the attachment.

THE WITNESS: Got it.

BY MS. RUANE:

Q. So this is a managed care speaker deck from 2007 regarding Fentora, correct?

A. That's what it says on the e-mail.

Q. You have no reason to disagree or dispute that, correct?

A. I -- there's nothing in this document that says anything about managed care.

So I'm -- I have no way of knowing if this e-mail is in conjunction with this deck.

Q. And I'll tell you the way that we, as attorneys, discern that is the number assigned to it, the last two digits there, 58, on the e-mail. And on that chronic pain document, the last two

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digits are 59.
So that's how we discern that that's the attachment that goes with it within our system.
But let me just ask you a couple of questions about it.
A. Sure.
MS. HILLYER: And sorry, again, to be picky, but the numbers on the deck, you wrote those in hand, right?
MS. RUANE: Oh, yeah, I'm sorry. On the page numbers, yes.
MS. HILLYER: Yes.
BY MS. RUANE:
Q. I should have clarified.
So because this document doesn't have page numbers, just for ease of reference, I added page numbers on the bottom so that we could follow along.
So if you turn to Page 5 --
A. I'm tracking with you now.
Q. -- you'll see there, Chronic pain overview?

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A. Yes.
Q. And below that, a bullet point for, Pain is pain, correct?
A. I see that.
Q. And that -- below that, it says, CA and nonCA patients.
That refers to cancer and noncancer patients, correct?
A. That's what it says.
MS. HILLYER: Objection to form. Calls for speculation.
BY MS. RUANE:
Q. That's your understanding of the CA reference within the Fentora documents is cancer, correct?
A. I don't know. It doesn't say cancer.
Q. Do you understand CA --
A. I do --
Q. -- to be cancer?
A. Oh, I've never seen -- I don't recall seeing this document before.
Q. But you would agree that the CA and nonCA patients'-pathophysiology,

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the same regardless of etiology or underlying disease, that that's referenced under pain is pain on Exhibit-15, correct?
A. I see the reference, yes.
Q. And this is a slide deck regarding Fentora, correct?
MS. HILLYER: Objection to form.
THE WITNESS: I'm just -- okay. There's nothing in this deck, other than the fact that it's on the Fentora template, that I'm seeing that says Fentora.
BY MS. RUANE:
Q. There is the reference to FEBT, correct, in the bottom right-hand corner?
A. That's what I just stated. Other than the template itself, as I go through this deck, this is -- it has many topics.
Q. I'm sorry, this is one of those times where it's -- I don't mean to

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be misstating what you're saying, I'm just trying to make sure I understand it and hear you.
A. Ask the question again.
Q. So this is a Fentora template, right?
A. This is a Fentora template, yes.
Q. And it's a slide deck that was provided to you in 2007, correct?
A. It was e-mailed to me.
Q. Yes.
It was provided to you via e-mail, correct?
A. It was provided to me, yes. I had a copy of it.
Q. And it references "pain is pain"?
A. In this deck, it does.
Q. And right below that, it references cancer and noncancer patients, correct?
A. Correct.
Q. Okay. And that would be

beyond the indication for Fentora, correct?
A. This is for speakers. This is not for promotional use by an account manager. That's what it states.
Q. Sorry. Go ahead.
My question was a little different.
You agree that is beyond the indication for Fentora, correct?
A. For Fentora, yes.
Q. And so Teva would provide speakers with these slide decks to use when speaking with managed care entities?
MS. HILLYER: Objection. Calls for speculation.
THE WITNESS: I don't know.
BY MS. RUANE:
Q. Well, it's a speaker deck -- you just clarified it's a speaker deck --
A. It is a speaker deck.
Q. -- for a speaker, correct?
MS. HILLYER: Objection to form.

BY MS. RUANE:
Q. For a physician?
MS. HILLYER: Same objection.
THE WITNESS: It says nothing here stating that. The only thing it says is -- I'm looking at the e-mail -- and Darren Keese, I don't even know who that is.
BY MS. RUANE:
Q. I'll tell you what, let's do this. I'm going to mark as Exhibit-16, the managed care presentation draft for review.
MS. HILLYER: We don't have a Bates?
MS. RUANE: TEVA_MDL09451760. And I can get you a native page for that, I apologize it wasn't on it.
- - -
(Whereupon, Teva-Bearer Exhibit-16, TEVA_MDL09451760, was marked for identification.)
- - -
BY MS. RUANE:
Q. And the first page of this document indicates it's a managed care presentation draft for review, correct?
A. Yes, that's what it says.
Q. So this would be a presentation.
It's on a Fentora template, right?
A. Yes, it is.
Q. Page 2 includes disclosures. So there would be -- it references, in the first bullet point, I'm an outside consultant retained by Cephalon, correct?
A. Correct.
Q. So this would be a document used by an outside consultant retained by Cephalon.
And this presentation was going to include, based on Exhibit-3, discussion of off-label uses of Fentora, correct?

A. Second bullet, in a response to an unsolicited request.
Q. I'm sorry, I meant to say the third bullet.
A. That's what the third bullet says.
Q. And that's a process that you were familiar with in your role with managed care, that physicians would be retained and paid by the company to speak on off-label uses of Fentora?
MS. HILLYER: Objection to form.
THE WITNESS: Upon unsolicited request.
BY MS. RUANE:
Q. So if there was an unsolicited request by a managed care entity, the next step would be for the company to have an individual physician retained by them go in to speak to the managed care entity on topics, including off-label use of Fentora?
A. If it was requested.

Q. So that's a correct statement?
A. If they requested broad use of Fentora, a presentation on that, then that would be -- that request would be fulfilled.
Q. Fulfilled, okay.
So at those presentations, would employees of the company, Cephalon and then subsequently Teva, be present?
A. I don't recall who would be present specifically, to be honest with you.
Q. Do you have any reason to think that the representative from the company would not have attended those presentations?
A. No.
Q. Okay.
A. Typically, it would be a medical person.
Q. Typically --
A. As I recall.
Q. Sorry. Just to make sure I

understand.
Typically a medical person --
A. Accompanying --
Q. -- within the company would attend?
A. Sorry. Accompanying a speaker.
Q. Got it. Accompanying a speaker?
A. Yes. Correct.
Q. I'm going to say it one last time, just to be sure.
A. Please do.
Q. So in your memory it would typically be an employee of the company within the medical department who would be accompanying the speaker to the presentation?
A. That's what I recall, yes.
Q. Got it.
Have you seen these managed care program slides before, this Exhibit-16?

A. It was e-mailed to me, so the answer is yes. But I don't know -- again, I'm confused about -- pardon me.
MS. HILLYER: Just to be clear, I don't know that this was part of that e-mail.
THE WITNESS: In that case, I don't know.
BY MS. RUANE:
Q. I'll figure that out on my end.
If it was e-mailed to you -- well, strike that.
Let me ask it this way: Do you have a memory of reviewing managed care presentations?
MS. HILLYER: For Actiq and Fentora?
MS. RUANE: For Fentora.
THE WITNESS: For Fentora? For promotion?
MS. HILLYER: For promotion, she said.
THE WITNESS: For promotion.

BY MS. RUANE:
Q. Let's ask it both ways.
Do you have a memory of reviewing managed care presentations for promotion of Fentora?
A. Yes.
Q. Do you have a memory of reviewing managed care presentations for speakers?
A. I don't -- I don't remember, honestly.
Q. Exhibit-16 that's before you, did you have any role or responsibility in reviewing or preparing this document?
A. Are we talking about this one?
Q. Yes.
A. Okay. Is there a date associated with this, by the way? Because that will help me give you --
Q. I mean, it would have been in the 2007 time frame, as best I can tell. There's citations in here to

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2006 --
A. No, I was not involved with this. This, again, is the -- for a physician speaker. I did not -- and my role was not to develop speaker program -- speaker slides for speakers.
Q. How could we tell -- how could we tell when a managed care presentation is for promotion and something that the managed care team would present? Like, is there a distinction made in the way they're named?
A. There should have been. If there wasn't, I don't recall. That's why I previously was asking you about the presentations. This is not something that an account manager would present. This stack.
Q. Okay. There's a separate version -- well, there's a separate type of presentation that went through the promotion committee to be approved that a managed care employee would present,

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correct?
A. A managed care employee would present? You mean a Cephalon employee under managed care would present?
Q. Yes. Yes.
A. We typically would name them managed care presentation for -- presentation for managed care decision-makers, that was the common --
Q. Managed care decision-makers?
A. Yes, that was -- I know of recently that's the way they have been done.
MS. HILLYER: The page numbers on that last one you guys put on, too, right?
MS. RUANE: Yes, correct.
I'm going to hand you Exhibit-17.
- - -
(Whereupon, Teva-Bearer Exhibit-17,

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TEVA_MDL_A_04420139-141, was marked for identification.)
- - -
BY MS. RUANE:
Q. You were involved in the hotline that was available to healthcare providers attempting to obtain coverage for products like Actiq and Fentora, correct?
A. When you say "involved," this was work for the entire Cephalon, the hotline.
Q. The hotline, as it relates to you --
A. Yes.
Q. -- we talked earlier about the fact that you were kind of the subject matter expert on managed care issues, right?
A. What time frame are you talking about?
Q. Well, let's talk about this e-mail first. This was in 2005.
That would have been part of

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your role, correct?
A. No. At this point, I was an account manager in the field.
Q. And you were copied on -- well, I guess the e-mail chain includes you?
A. Yes.
Q. And is referencing some questions about the hotline for national account managers.
Do you see that?
MS. HILLYER: Give her a minute to look it over.
THE WITNESS: Okay. Ask your question again.
BY MS. RUANE:
Q. Okay. The hotline possesses tools needed, such as LMN templates and other documents that are a part of creating prior authorization or appeals documentation, right?
Is that the way -- I mean, I can --
MS. HILLYER: Objection.

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BY MS. RUANE:
Q. -- ask it more generally if it's easier and faster, okay?
One of the things that would happen with the hotline was providers could call the hotline and the hotline had tools, like letters of medical necessity templates, correct?
A. Correct.
Q. There may be other documents that help with prior authorization or an appeals documentation issue, right?
A. Correct.
Q. And so what the hotline was intended to do, at least in part, was help patients secure coverage for the products carried by Cephalon and then Teva, right?
A. It was -- the intent of the hotline was to help the physician's office and/or the patient navigate the process to submit prior authorizations for access.
Q. Okay.

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A. It's about the process.
Q. And sometimes --
MS. RUANE: I'm going to hand you what's been marked as Exhibit-18.
- - -
(Whereupon, Teva-Bearer Exhibit-18, TEVA_MDL_A_04848188-191, was marked for identification.)
- - -
MS. RUANE: For the record, this is TEVA_MDL_A_04848188.
BY MS. RUANE:
Q. I'll give you a second to review it.
MS. HILLYER: It's tiny, the print.
THE WITNESS: Okay. Maybe with your question I'll need to read it again, but go ahead.
BY MS. RUANE:
Q. The e-mail chain starts off with an e-mail from -- on Page 89, with

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an e-mail from Alec Burlakoff?
A. Yes.
Q. And he's describing a situation where a call was made to the hotline.
And the first question asked was, Does this patient have cancer?
Do you see that?
A. Yes, I do.
Q. And the office staff said no.
Do you see that?
A. Yes.
Q. And the person from the hotline says, Sorry, we cannot help you, have a nice day, and hung up.
Do you see that?
A. Yes, I see that.
Q. The discussion is, it's described as a mishap by Alec, correct?
He says, I truly believe these mishaps are partly the reason for the lack of hotline usage. It is a shame.

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A. That's his opinion.
Q. The e-mail is then forwarded to you --
A. Yep.
Q. -- from Randy Spokane. And you forward it on and indicate, I am concerned -- this is at the top of 89.
I am concerned about this incident and the possibility of these situations arising. Fortunately, the representative at the physician office -- was at the physician office and was able to address the miscommunication as it occurred.
Do you see that?
A. I see that.
Q. And then there's some discussion of different possibilities for why that might have happened that way.
But, ultimately, at the top of Page 88, Randy clarifies the initial reason for the call was for a noncancer patient.
Do you see that?

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A. Yes.
Q. So this was a call for a patient who would be receiving Actiq for an off-label purpose, correct?
A. That's what that -- that's what -- I'm sorry. That's what Randy states.
Q. And so the hotline was correct to ask whether the patient had cancer, because that's the indication for the drug, correct?
MS. HILLYER: Objection to form.
THE WITNESS: That is not correct.
BY MS. RUANE:
Q. The question, does this patient have cancer, is intended to determine whether this is a patient within the indication for the label of the drug, correct?
A. No.
Q. Why not?
A. I can't -- if you read Lynn

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Macilwain on the first page, patient assistance program. Our patient assistance program is different than the hotline, although they facilitated the call.
And the patient assistance program was only for patients with breakthrough cancer pain.
Q. But you were concerned about the possibility of patients who don't have cancer not being able to move forward through the hotline and obtain additional information in order to seek reimbursement, correct?
A. No. The issue would be, based on my recollection, the training of the customer service hotline.
The first question you don't have to -- you would not necessarily have to -- you wouldn't ask, is the diagnosis. The hotline is providing reimbursement support services, to include prior auth forms, although we talked about, not based on diagnosis.

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Q. So it would be your expectation, and the reason you were following up was so that the hotline was not seeking information that would determine whether a patient had cancer --
MS. HILLYER: Objection to the form.
BY MS. RUANE:
Q. -- as the initial question on the call?
A. The reason I was following up is if this was a patient assistance program, it may be appropriate to ask that, because the patient wouldn't qualify, you know, for patient assistance.
And there was a warm transfer, as I recall, for the patient assistance program, which was sort of there was a firewall between reimbursement hotline services and the patient assistance program, or otherwise referred to as PAP.
Q. And if this wasn't a patient

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assistance program call --
A. Yes.
Q. -- if this was just a call for a patient of any other sort, your expectation is that whether they were a cancer patient would not be relevant to whether the hotline was providing services to them for reimbursement?
A. Correct.
Q. Because the purpose of the hotline was to provide reimbursement services, even if the patient did not have cancer, correct?
A. It was not based on diagnosis. There may have been prior auth criteria beyond the diagnosis, of which, again, navigating the process for coverage was relatively foreign to a lot of these offices, and that was the intent of the service.
It was up to the physician to determine what was an appropriate patient and go through that process.
Q. But the intent of the

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service, to the extent possible, was to provide reimbursement services for uses -- for use of the product even if it is beyond the indication on the label, correct?

MS. HILLYER: Objection to the form.

THE WITNESS: Why don't you rephrase that for me so I can give you a concise answer?

BY MS. RUANE:

Q. The purpose of the hotline was to provide reimbursement services to a provider, even if the particular patient did not fall within the indication on the label?

A. The diagnosis is not included in a reimbursement support service. It's just not. It's not a screening based on your indication.

Q. So you would agree, then, that the hotline was not screening based on whether a patient was receiving services on indication -- within the

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indication or outside of the indication?

A. They would -- if they wanted reimbursement support services, typically the prior auth form would be sent to the office staff. The office staff includes relevant information, to include diagnosis.

And the part of the -- part of the reimbursement support service was to help facilitate that process not specific to diagnosis. There's lots of information required on pre-A forms.

Q. Are you aware of the fact that Burlakoff pled guilty for illegal promotion of a product by your competitor, Subsys?

MS. HILLYER: Objection. Calls for speculation. Assumes facts not in evidence.

BY MS. RUANE:

Q. Are you aware of that?

A. No.

Q. Do you know Alec Burlakoff?

A. No.

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Q. When you received this e-mail, you were -- and received Randy's e-mail indicating the initial reason for the call was for a noncancer patient, you were aware of the fact that that would be a patient, then, who was prescribed the drug for off-label use, correct?

A. Correct.

Q. And you're aware of the fact that for a while, at least, the hotlines had at their disposal letters of medical necessity as one of the tools to facilitate reimbursements?

A. There was a period of time. I don't recall how long it was, actually.

Q. The letters of medical necessity included a range of conditions, and you would agree some of those conditions were off-label uses, correct?

A. As I recall. I don't have a recollection of exactly what they were.

Q. We can get them out if we need to.

A. Okay.

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Q. But, for example, there might be a letter of medical necessity related to back pain?

MS. HILLYER: Objection. Calls for speculation. She said she doesn't remember the specifics.

BY MS. RUANE:

Q. Do you have a memory of that?

A. No.

Q. Okay. Actually, before I bring up another exhibit, let me ask you, those letters of medical necessity were used, I know you don't remember exactly when, it looks to me from 2008 to 2011.

Would that be consistent with your memory, or do you know?

A. I don't know the dates.

Q. Okay. Do you know why the letters of medical necessity program was discontinued in 2011?

A. No.

Q. Did anyone ever talk to you

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about the reason for the discontinuation of that program?
A. No, not -- no, I don't recall having a conversation about it.
Q. Are letters of medical necessity still used for on-label use of the products?
MS. HILLYER: For Actiq and Fentora?
THE WITNESS: For Actiq and Fentora?
BY MS. RUANE:
Q. For Fentora.
MS. HILLYER: Objection to form.
You can answer if you know.
But she's not in that role anymore.
THE WITNESS: We don't support Fentora.
BY MS. RUANE:
Q. A better question might be, during the time that Fentora was on the market --

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A. Yes.
Q. -- being supported, were letters of medical necessity for the within-indication use of Fentora still available, even after the off-label letters of medical necessity had been discontinued?
A. I don't recall.
Q. Okay. Do you have any reason to think that that didn't continue to occur?
A. I find it interesting that we would need a letter of medical necessity if the patient was eligible for the product.
The idea is if there's some reason -- and if there was some reason that they would, then there may be a template to follow.
MS. RUANE: I'm going to hand you what's been marked as Exhibit-19. For the record, this is TEVA_MDL_A_01204074 through 092.

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- - -
(Whereupon, Teva-Bearer Exhibit-19, TEVA_MDL_A_01204074-092, was marked for identification.)
- - -
BY MS. RUANE:
Q. This is a Vantrela strategic brand plan.
And you were involved in the strategy associated with the Vantrela project -- product, correct?
A. As it related to market access, yes.
Q. So within market access, one of your jobs was to determine whether managed care would pay for a product like Vantrela?
A. Yes.
Q. Were you involved in the creation of the strategic brand plan for Vantrela?
A. The brand plan itself, no.
Q. What portion of the Vantrela

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strategy would you have been involved in?
A. Payer strategy.
Q. Got it.
And the payer strategy would be the strategy for, basically, building the case for payers to understand the benefit of providing coverage for a drug like Vantrela?
A. Correct.
Q. One of the things that is relevant in providing -- making the case to payers for why coverage for a product like Vantrela is important is establishing the need for abuse-deterrent technology in drugs, correct?
MS. HILLYER: Objection to form.
THE WITNESS: A treatment -- I would say a treatment option for patients.
BY MS. RUANE:
Q. And so in the strategic brand plan that was created by Teva, on Page 4, Number 1, the first topic there

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on the executive summary is, Abuse and misuse of opioids.
Do you see that?
A. Sorry.
Yes.
Q. It talks about, The prevalence of prescription opioid abuse and misuse that has increased in the past decade and poses a serious public health issue.
Do you see that?
A. Yes.
Q. Do you agree with that characterization?
MS. HILLYER: Objection to form. And also lack of foundation. She testified that she didn't have anything to do with this document.
BY MS. RUANE:
Q. We can go on and look at some others that you did.
I'm just asking you right now, as it relates to the prevalence of

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opioid abuse and misuse that's increased over the past decade and now poses a serious public health issue, is that something that you personally believe to be true?
MS. HILLYER: Objection to form.
THE WITNESS: I don't have -- I'm not going to offer my opinion.
BY MS. RUANE:
Q. Do you hold an opinion?
MS. HILLYER: Objection to form. It calls for speculation. She's not an expert on this.
BY MS. RUANE:
Q. Ms. Bearer, I'm just asking you, do you have an opinion as to whether there's an opioid epidemic that's causing a public health crisis right now in our nation?
MS. HILLYER: Objection to form.
THE WITNESS: As it relates

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to what you were asking me -- I mean, no.
BY MS. RUANE:
Q. You don't believe that to be true?
A. I'm answering the question based on what you provided me here. There's no --
Q. I just want to make sure I understand your answer.
You don't believe that there is a serious public health issue that's posed by the prevalence of prescription opioid abuse and misuse in our nation over the past decade?
MS. HILLYER: Objection to form.
THE WITNESS: If you're asking -- sorry.
There are statistics to suggest that there is an opioid epidemic. I don't have any -- I did not have anything to do with this document. So that was my

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previous answer.
BY MS. RUANE:
Q. But you have seen the statistics related to the opioid epidemic and the societal cost associated with that?
A. Yes.
MS. HILLYER: Objection to form.
THE WITNESS: Sorry.
BY MS. RUANE:
Q. Did you see those documents as you prepared part of the brand plan associated with managed care and Vantrela?
A. It was part of the --
MS. HILLYER: Sorry. Objection. What documents?
THE WITNESS: Yeah, I mean, what --
BY MS. RUANE:
Q. The -- let's do this.
- - -
(Whereupon, Teva-Bearer

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Exhibit-20, TEVA_MDL_A_09191592-593, with attachment, was marked for identification.)

- - -

MS. RUANE: I'm going to hand you what's been marked as Exhibit-20. For the record, this is TEVA_MDL_A_09191592.

THE WITNESS: Are we finished with this one?

MS. RUANE: For now.

BY MS. RUANE:

Q. This document includes a managed care overview for Vantrela on Page 248?

A. Yep.

Q. And this is a document that you --

MS. HILLYER: You said 248?

MS. RUANE: 248, yes.

MS. HILLYER: Oh, sorry, hold on. 1592, 1593 -- these are not sequential. 191593, and then

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I jump to 83248.

MR. GASTEL: It's the attachments to previous e-mails.

MS. HILLYER: But this e-mail has several attachments which aren't attached here.

MS. RUANE: Let's do this --

MS. HILLYER: And there's no -- the earlier e-mail doesn't appear to have any attachments.

BY MS. RUANE:

Q. Let me ask you this, and then we'll sort out where to go.

The document, 248, the managed care overview --

A. Got it.

Q. -- is that a document that you created?

A. Yes.

Q. On Page 252 of that document -- and, again, this is a managed care overview to be provided as it relates to the Vantrela product, right?

A. Correct.

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Q. Okay. On 252, you identify the fact that the misuse, abuse and diversion of opioids is a major public health concern, correct?

A. Yes. And they are all referenced.

Q. And if you look at the bottom, your references are there?

A. Correct.

Q. And you identify the fact that one in twenty Americans over 12 abused opioids in 2010, correct?

A. Based on the reference, correct.

Q. You also identify the fact that one in three drug-related emergency room visits were opioid related in 2011, correct?

A. Yep.

Q. And you cited 18,000 overdose deaths in 2014, correct?

A. Cited it.

Q. You included it in there with the citation?

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A. Yes, I'm sorry. That's what I said. Sorry. Cited, yes.

Q. Sorry. And you also identified a more than 300 percent increase in overdose deaths from 1999 to 2014, correct?

A. Correct.

Q. And those are statistics that you identified and chose to put in the managed care overview for Vantrela, correct?

A. Correct.

Q. They were significant statistics to you?

MS. HILLYER: Objection to form.

THE WITNESS: That's an opinion. They were factual.

BY MS. RUANE:

Q. They're factual.

And they're persuasive when explaining to a managed care entity why reimbursement for an abuse-deterrent technology would be appropriate, correct?

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MS. HILLYER: Objection to the form. And calls for speculation.
THE WITNESS: They are facts.
BY MS. RUANE:
Q. And they're facts you chose to put in here for a reason, right?
A. They are facts. We are looking at an abuse-deterrent formulation, and these are facts associated with, perhaps, the unmet need.
Q. With, I'm sorry?
A. These are facts associated with that reference. That's what I'm saying.
Q. They're facts associated with the opioid epidemic and opioid abuse, correct?
A. The word we use is a misuse, abuse and diversion.
Q. Okay. They are facts that are significant to explain to a managed care facility just how dire the opioid

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use, abuse and diversion has become in America, correct?
MS. HILLYER: Objection to form.
THE WITNESS: They are facts associated with -- they are just facts relative to opioid abuse, diversion and misuse, which is on the next slide, I believe. Unless I'm going backwards.
BY MS. RUANE:
Q. On Page 255 -- sorry, it's because of the staples --
A. I'm going in the wrong direction.
Q. It says at the top, Opioid abuse poses a substantial economic burden.
Do you see that?
A. Uh-huh.
Q. That's information -- you typed that in, right, as you created this document, correct?
A. I created the document.

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Q. And you chose to define it as, Opioid abuse posing a substantial economic burden, right?
A. Economic, yes.
Q. And you include the fact that there's, in the United States, in the year 2015 there's $27.6 billion in healthcare costs, correct?
A. Yes. And that's a -- yes.
Q. You also included $28.3 billion in workplace costs?
A. Yes.
Q. And $5.6 billion in criminal justice costs?
A. That's correct.
Q. For a total societal cost, in 2015 alone, of $61.5 billion, correct?
A. Correct.
Q. My question for you is, who do you believe should pay for the $61.5 billion per year in total societal cost?
MS. HILLYER: Objection to form.
THE WITNESS: You're asking

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my opinion?
BY MS. RUANE:
Q. Yeah. I'm asking whether you believe that it's appropriate and fair for the companies that profited from the use, abuse and diversion of opioids to pay for the societal cost that America is now facing?
MS. HILLYER: Objection to the form.
THE WITNESS: I don't know.
MS. HILLYER: And assumes facts not in evidence.
BY MS. RUANE:
Q. Is it your belief that American taxpayers should bear that cost?
MS. HILLYER: Objection to form.
THE WITNESS: I really don't know.
BY MS. RUANE:
Q. Between American taxpayers and the companies that profited from the sale of opioids, wouldn't you agree that

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the appropriate thing to do would be for those companies to forfeit those profits in order to address the societal costs that they have created?

MS. HILLYER: Objection to form. And assumes facts not in evidence. And calls for a legal conclusion.

BY MS. RUANE:

Q. Wouldn't you agree, Ms. Bearer?

MS. HILLYER: Same objections.

THE WITNESS: I'm not an attorney. You're asking for me to provide you a response that implies a legal reference that -- I'm sorry. I'm not an attorney.

BY MS. RUANE:

Q. And with all respect, I'm not asking for an opinion -- or a legal opinion right now.

I'm -- I understand that you identified, as an important thing for

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third-party -- well, strike that -- for managed care entities to know is that there's $61.5 billion a year right now that American society is bearing as a result of the opioid epidemic.

A. Yes.

MS. HILLYER: Objection.

BY MS. RUANE:

Q. And because that's a decision -- or that's information that you found significant at the time of working on Vantrela, I'm wondering what your personal opinion is as to who bears the burden for that cost.

MS. HILLYER: Objection to form. Mischaracterizes the document. Assumes facts not in evidence. And same objections I made before. And asked and answered repeatedly now. She's answered your question.

BY MS. RUANE:

Q. I won't -- you can answer it one more time. I won't ask it again.

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MS. HILLYER: Same objections.

THE WITNESS: I'm not an attorney and, therefore, cannot provide an opinion as to -- to answer your question.

MS. HILLYER: Sarah, do you want to separate these as documents, because they don't actually belong together? Or how do you want to --

MR. GASTEL: They definitely belong together. There's just numerous attachments and they are all not --

MS. HILLYER: So it's just missing the in-between attachments you're saying? I see. As long as we're clear on the record, that's fine.

THE WITNESS: Are we finished with this?

MS. HILLYER: That one goes before that.

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THE WITNESS: So we're finished with both of them, okay. Sounds good.

MS. HILLYER: We've been going about an hour. If you have another quick document, we can do it, but --

MS. RUANE: Let's take a quick break.

VIDEO TECHNICIAN: Going off the record. 2:25.

- - -

(Whereupon, a brief recess was taken.)

- - -

VIDEO TECHNICIAN: Back on record at 2:39 p.m.

BY MS. RUANE:

Q. We're back on the record after a short break.

You understand you're still under oath?

A. I do.

Q. We're going to hand you

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what's been marked as Exhibit-21.

- - -

(Whereupon, Teva-Bearer Exhibit-21, TEVA_MDL_A_09165564-565, with attachment, was marked for identification.)

- - -

BY MS. RUANE:

Q. And there's the e-mail itself which, for the record, is TEVA_MDL_A_0916564 to 65, and then the attachment is included on the back there.

This is a managed care mag article for opioids.

This is an e-mail chain that includes you and Jeff Dierks, at least at the top.

Do you see that?

A. I do.

Q. Who is Jeff Dierks?

A. He was the brand director at the time for Fentora.

Q. You said brand director for

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Fentora?

A. Yes.

Q. You wrote Jeff about the article titled, The Societal and Economic Burden of Chronic Pain and Opioid Abuse, correct?

A. Yes.

Q. Do you remember this?

A. It's coming back to me.

Q. In your e-mail to Jeff, you reference the fact that there is no collaboration -- you said, I had no knowledge of this.

Are you referring to the article itself?

A. Yes.

Q. That's a yes?

A. Yes.

Q. I didn't hear you.

You indicate, There is no collaboration with regard to the market access strategy.

Do you see that?

A. Yes.

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Q. What do you mean by --

A. Sorry.

Q. What do you mean by "market access strategy"?

A. I mean as referenced prior, where I would lead the market access subteam.

So Jeff would have been the brand director over the entire brand strategy. And my portion of the market access strategy was not -- is what, you know, I leaded, like, a subteam, for example, basically.

Q. And so the market access subteam would be dealing with how to properly brand and market to the managed care facility -- or managed care entities, correct?

A. We would provide input, if nothing -- so to be clear, market access, my team still falls under the umbrella of the brand as a total, the brand strategy, minus just a subset.

Q. So your team is actually

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under the brand team for Teva?

A. I did not report in to the brand team. But I am a dotted line representing the market access payer strategy.

Q. Okay. What is -- is there a line up above brand? What does it go to? Or is brand one of the top --

MS. HILLYER: Objection to the form.

BY MS. RUANE:

Q. -- entities?

I may not be explaining that right. It may just be a bad question. Let me try again.

What about marketing, are marketing and brand on the same level?

A. That's the same thing, sorry.

So when we say "brand," we're saying brand marketing, I apologize.

Q. So your managed care position had a dotted line to

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brand/marketing?
A. Correct.
Q. The market access strategy that's being discussed here as it relates to managed care, were you responsible for managing a budget and --
A. Yes.
Q. -- and implementing certain marketing, as a result, to managed care facilities?
A. We don't market to. We would have projects associated with developing a strategy. And that was the budget.
That was what the budget was used for, payer research, all sorts of things along those lines.
Q. Do you recall, for example, in the year 2015, the estimate of what your budget was that you were handling?
MS. HILLYER: For Fentora?
BY MS. RUANE:
Q. For Fentora.
MS. RUANE: That's a good

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point. Thanks.
MS. HILLYER: Assumes facts not in evidence.
THE WITNESS: I would be guessing if I told you. I don't recall specifically. I had other brands.
BY MS. RUANE:
Q. And within your budget, were there line items for sales presentations?
A. No.
Q. What were the line items within your budget?
A. They were extensive. Can you be more specific of what you're trying to get to? And I'll be happy --
Q. I'm trying to make sure I understand, when you talk about the market access strategy, what your -- what all the responsibilities were, or potential, you know, marketing, for lack of a better word, that you had at your disposal within your budget.
MS. HILLYER: Objection to

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form. You mean as to all the products that came under her umbrella?
MS. RUANE: No.
BY MS. RUANE:
Q. Is your budget divided up by product?
A. Yes.
Q. So let's take Fentora.
A. Yes.
Q. What were the kind of line items or potential options that you would have under the Fentora budget that you managed for market access strategy?
MS. HILLYER: Objection to form. Vague as to time frame.
THE WITNESS: So if -- specifically, the projects are dependent on the time frame. So if you want to give me -- if you go to a long strategy, the projects are different as you evolve a strategy.
BY MS. RUANE:

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Q. So in -- when Fentora launched, let's talk about the 2007/2008 time frame, what types of line items would have been in that budget?
A. It would have been the development of a payer presentation tactic specifically for -- at the launch, it would be tactics, primarily, for the account management team.
If there was a vendor that we needed, and I don't recall, I'm giving an example, for, say, a budget impact model or something of that nature, those are the examples.
But I don't have specifics for you for Fentora, frankly.
Q. You mentioned in the e-mail that the market access strategy requires extensive payer research?
A. That's correct.
Q. What do you mean by that?
A. To develop a strategy, you can either have advisory boards, you can do market research, you identify -- you

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have a third party to identify a population representative of, say, commercial payers. It's blinded. The third party engages.

There are objectives and research. And that research comes back and it is taken into consideration as you're developing your value proposition for the payer and messaging.

That's one example.

Q. And you all engaged in that process with the drug Fentora?

MS. HILLYER: Objection to form.

THE WITNESS: That would be -- that would be the norm. If you're asking me specifically during that time, it was a partnership between marketing and my role.

BY MS. RUANE:

Q. Okay. You also reference targeting patient profile, message testing and positioning, et cetera.

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A. Yes.

Q. Explain for me what you mean there.

A. The target patient profile, you paint a picture for the physician -- sorry, the payer as to the appropriate population where a product would be -- would be appropriate -- sorry, appropriate for, you know, characterizing the enrollment within a plan, who is the appropriate patient, based on research. Sometimes analogs are used.

I'm sorry, you asked me about target patient population?

Q. Yes.

A. Payers want to quantify how many patients in their plan would be candidates for a therapy. So through research, we're able to at least make some assumptions.

And unless you want me to go into all the details of how you do that, it's extensive. You can look at analogs. You can have one-on-one conversations

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with payers. But it's all third-party facilitated.

Q. So one of the things that concerns you about the article that is being referenced in your e-mail is the fact that you weren't consulted on how to appropriately paint the picture or address market access strategy, correct?

A. No.

MS. HILLYER: Objection to form.

BY MS. RUANE:

Q. You define -- or in your e-mail you describe this article as a promotional tactic?

A. I'm trying to remember where it was published.

I'll tell you what I was upset about is it was done in a vacuum, and I wasn't consulted. I didn't have an opinion one way or the other, as I recall, about the content itself.

But from a role and responsibility, anything that touched

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managed care would have been -- at least I would have been involved with. And this was done in a silo, and that's really the tone of this.

So why wasn't I consulted and I'm hearing about it after the fact?

Q. You do describe the article as a promotional tactic, correct?

A. Well, because, I guess, it went through PARC and it went through -- I'm trying to remember where it was published. Disease State Report.

So this is not a scientific publication, as I remember. Therefore, it would be considered -- it's not like we would use it in promotion. It's just a matter of certain publications -- our medical team is the publication team. We have nothing to do with that.

This is -- if we submit an article or have -- or if there's an article submitted that we had any editorial content with, it's not considered scientific in general.

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Q. It's considered promotional and it goes through PARC, correct?
A. That's what I'm told here, this went through PARC.
Q. And what is PARC?
A. Promotional advertising review committee. It's our medical/legal/regulatory. It's just an acronym.
Q. I'm sorry, say that again. Promotional --
A. We have too many acronyms. Promotion and advertising review committee, I believe. We just call it PARC. You get used to it, and you don't know what it means.
Q. So PARC, the promotional advertising review committee, you mentioned medical/legal there. And I want to make sure I understand what you were saying.
Is there a medical review that occurs when items are submitted to PARC?

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A. So PARC is a committee. On the committee is an attorney, a regulator and a medical.
Q. But the items that are submitted to PARC are items -- the submission to PARC is separate and apart from items submitted through medical services, correct?
A. Yes.
Q. Okay. And items submitted through PARC, members of the managed care team may discuss during their interactions with managed care entities, correct?
A. That would depend.
Q. They aren't prohibited from doing so, correct?
A. The way our PARC works is the audience has to be a part of the project. So there will be sales as the audience -- HCPs, so those will be sales pieces. There will be managed care decision-makers, that would be a piece that a rep wouldn't have access to.

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Q. And in the example here, this article was submitted to PARC, was then published, it looks like, maybe in a managed care magazine?
MS. HILLYER: Objection to form.
THE WITNESS: I really don't know.
BY MS. RUANE:
Q. The link at the end says Managed Care Mag.com, so.
Is Managed Care Magazine something you're familiar with?
A. Yes. Yes, that would be.
Q. You also criticize the caliber of the managed care experts and indicate they would have been held to a higher standard if you had the opportunity to weigh in.
Do you see that?
A. I see it.
Q. What was your criticism of the experts used?
A. I'd have to go back and read

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it. I apologize, I don't remember.
Q. I'll just tell you, on Page 5 you can see who they are.
A. Okay. Thank you.
Well, I was forming an opinion based on the way, at the time, I interpreted the level of knowledge or background and the credibility, potentially.
It was probably an emotional response to the fact that I wasn't involved. But I'm not familiar with either of these two individuals. And the target audience for an article like this would have been other managed care organizations.
Q. It indicates -- you're familiar with Pain Matters?
A. I'm familiar with it. I mean, I know of it. I had nothing to do with any -- no involvement whatsoever with Pain Matters.
Q. Okay. Who was involved with Pain Matters, if you know, and the

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implementation of that?
A. The only individual that comes to mind is Matt Day. There may have been others.
Q. Did you advise or serve as a supervisory role with Matt Day on Pain Matters?
A. No.
Q. Have you been to the Pain Matters website?
A. No.
Q. This e-mail references the fact that they leverage Pain Matters content.
Are you aware of what Jeffrey Dierks was referring to when he said that in his response to you?
MS. HILLYER: Objection. Calls for speculation.
THE WITNESS: No.
BY MS. RUANE:
Q. So you hadn't weighed in on any Pain Matters content?
A. No, no.

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Q. Do you have a general understanding that Pain Matters was used to educate and promote on the issues of chronic pain?
MS. HILLYER: Objection. Calls for speculation. And lack of foundation.
THE WITNESS: I've not gone on the website and gone through Pain Matters.
BY MS. RUANE:
Q. In your role with marketing and strategic planning, did you -- were you -- did you sit in on any meetings addressing Pain Matters and the implementation of Pain Matters?
A. I recall meetings in which it would have been a cross-functional brand team meeting with updates, not content.
Q. And during those updates, did you gain an understanding that Pain Matters was a campaign being launched by the company to educate on the issues of

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chronic pain?
MS. HILLYER: Objection. Calls for speculation. Lack of foundation.
THE WITNESS: I never saw anything that said, this is what -- you know, the intent. I don't recall seeing any document that said Pain Matters is intended to.
BY MS. RUANE:
Q. Sitting here today, do you have an understanding of what Pain Matters is?
A. It's exactly as you described it, based on what I have heard. But, again, I have not gone through the website.
In my role with payers, this is not something that would involve the payer community.
Q. Okay. But just based on sitting in meetings and hearing updates from different departments, your memory

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is that it's as I described it, a resource to educate on chronic pain?
A. The way I understood it was it was a resource to educate on pain. That was the way I took it. I don't ever recall specifically chronic pain as being the focus. I don't recall.
Q. At the time of this e-mail in 2015 --
A. Yep.
Q. -- what branded opioids for chronic pain were being sold by Teva at the time?
A. Are you asking -- oh, branded. Branded for chronic pain. We did not have a product for chronic pain.
Q. And how was this piece a promotional tactic if there were no branded chronic pain products on the market from Teva at that time?
A. I can't answer that, because I didn't create the -- I did not create the -- I had nothing to do with the article. I did not sit on the PARC team.

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I don't know how it was presented to PARC. And I don't know what criteria they used for approval.
Q. What you know is that it seemed to you to be a promotional tactic, right?
A. It did seem to be a promotional tactic.
Q. And that was further confirmed to you by the fact that it was submitted to PARC, correct?
A. I have no knowledge of it actually being in PARC. Everything that I reacted to in this is predicated on this e-mail.
Q. And on this e-mail chain -- the only reason I ask that is because on this e-mail chain, it indicates Matt Day submitted this to PARC.
A. That's correct.
Q. So that's further indication that it was promotional material being provided in November of 2015, correct?
A. He is a marketer. If he

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submitted it to PARC, it would be my opinion, at the time -- I mean, that's the way I interpreted it.
Q. I'm just wondering what drug was being promoted, then, if there were no branded opioids for chronic pain on the market from Teva?
MS. HILLYER: Objection to form.
THE WITNESS: The way I interpret this it that it was more or less talking about educating on pain, not specific to any product.
MS. RUANE: I don't think I have any further questions, but Mr. Madden is going to get the chance to talk to you now.
MS. HILLYER: Sorry. So if I have redirect on some of this, I should do that now, or do you want me to do it after? How do you want me to do that? I guess it doesn't really matter --
MR. MADDEN: I say we go and

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then you do your redirect.
MS. HILLYER: We can do that. That's okay by me.
VIDEO TECHNICIAN: Going off the record, 3:00 p.m.
- - -
(Whereupon, a brief recess was taken.)
- - -
VIDEO TECHNICIAN: Back on record at 3:13 p.m.
- - -
EXAMINATION
- - -
BY MR. MADDEN:
Q. Ms. Bearer, I'm Brian Madden. I represent the plaintiffs in this MDL matter.
I am not going to ask you questions that prior counsel asked you, but just have a few things for you.
You started at Cephalon in 2003 --
A. Correct.

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Q. -- correct?
A. Yes.
Q. And you were in managed care from the beginning?
A. Yes.
Q. You were at Cephalon when the company pleaded guilty with regard to off-label prescription of drugs, including Actiq?
MS. HILLYER: Objection to form.
BY MR. MADDEN:
Q. Is that true?
A. I was employed, yes.
Q. Yes.
Were you made aware of that guilty plea at the time of your employment?
A. Yes.
Q. And that was in approximately the fall of 2008; is that right?
A. I believe so, yes.
Q. Were you disciplined at all

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with regard to that guilty plea for off-label marketing of Actiq?
A. No.
Q. Did you lose your job as a result of that guilty plea?
A. No.
Q. Who did lose their job at Cephalon as a result of that guilty plea?
MS. HILLYER: Objection. Calls for speculation.
THE WITNESS: I really don't know.
BY MR. MADDEN:
Q. Do you know of anyone at Cephalon who lost their job as a result of the off-label marketing guilty plea for Actiq?
MS. HILLYER: Objection. Calls for speculation.
THE WITNESS: I really don't know.
BY MR. MADDEN:
Q. Prior to 2008, in your role in managed care, were you made aware by

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the company of the rules with regard to off-label marketing versus on-label marketing?
A. Yes.
Q. You were trained on that?
A. Yep.
Q. Did you take modules regarding that?
A. I don't remember specifically. Most likely, yes. We take a lot of modules.
When you're talking time frame, I just don't have the specific time frame.
Q. But it's fair to say you knew, prior to 2008, what the rules were with regard to legal, on-label marketing of a drug like Actiq; is that true?
A. Yes.
Q. Now, two documents that Ms. Ruane discussed with you, let's first look at Exhibit-12.
And I believe you have paper versions, but we can also put them up on

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the screen, if that helps you.
A. It's easier for me, if you don't mind, to read the hard copies.
MS. HILLYER: They are numbered on the bottom. It should be in order.
THE WITNESS: I see. I got it.
MS. HILLYER: It's this one.
THE WITNESS: The dossier.
BY MR. MADDEN:
Q. Exhibit-12 was marked as the Actiq managed care dossier, correct?
A. That's correct.
Q. And do I recall your testimony correctly that a dossier such as this would be sent to a managed care provider if they requested it?
A. That's correct.
Q. This was not promoted to a managed care entity, but, rather, if they asked for it, this would be sent by the company to them; is that true?
A. Yes.

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Q. And if any of the issues discussed on Page 1 of Exhibit-12 were requested from Cephalon, this would be sent to the managed care provider, correct?
A. I'm sorry, what?
Q. Bad question.
If a managed care provider had a question about any of the subjects on Page 1 of Exhibit-12, they could ask the company for this dossier, correct?
A. Let me rephrase.
If they had a question on, say, breakthrough pain specifically --
Q. Yes.
A. -- they wouldn't necessarily know what was in the dossier. Typically, when they request the dossier, they request the dossier.
Q. Fair enough.
A. Okay.
Q. If a managed care entity or payer had a question under Section 5.0, Risk of opioid abuse by patients with

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chronic pain, and that question were submitted to Cephalon, then Cephalon could send this dossier to that managed care entity, correct?

MS. HILLYER: Objection to the extent it calls for speculation outside her knowledge.

THE WITNESS: I don't know. This was handled through medical, not through my side of the business.

BY MR. MADDEN:

Q. We can look at the dossier.

And if this dossier went to a managed care entity, it does discuss risk of opioid abuse by patients --

A. Yes, it does.

Q. -- for chronic pain, true?

And if we go to Page 23 of this document.

MR. MADDEN: The last sentence, last two sentences before Section 5.2, would you highlight those for me, please?

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THE WITNESS: I'm sorry, say that again.

BY MR. MADDEN:

Q. Beginning with, Extensive.

A. Extensive clinical experience with the use -- you want me to read it?

MS. HILLYER: No. He was asking him to highlight that.

She wasn't aware of that.

MR. MADDEN: I'm actually talking to the tech.

BY MR. MADDEN:

Q. Ms. Bearer, I point your attention, in Exhibit-12, to the highlighted language from Page 23 in the Actiq dossier which says, Extensive clinical experience with the use of opioids for patients with cancer pain indicates that the risk of addiction in this population is very low. Similarly, the risk of abuse is low in patients with nonmalignant pain, though there is less experience in this patient population.

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Do you see that language?

A. Yes, I do.

Q. Now, we also looked at another exhibit that you prepared, Exhibit-20, which was a slide presentation with regard to Vantrela.

Do you recall that?

A. Yes.

Q. And you accumulated data and put that data into your slides and cited to that data with regard to --

A. Yes.

Q. -- opioid abuse and diversion, correct?

A. Correct.

MS. HILLYER: Objection to form.

BY MR. MADDEN:

Q. So let's pull up Exhibit-20. And I'll reference you to Page 09183260.

A. I'm out of order here.

MS. HILLYER: One second here.

260? Sorry, do you have

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the -- so this is Exhibit-20. So it should be --

- - -

(Whereupon, a discussion off the record occurred.)

- - -

BY MR. MADDEN:

Q. Ms. Bearer, this is part of the slide deck you put together with regard to Vantrela, correct?

A. That's correct.

Q. And Vantrela was an abuse-deterrent opioid that was developed by Teva, correct?

A. Correct. Yes.

Q. Okay. This is one of the slides you put together, right?

A. Yes.

We're on 60?

MS. HILLYER: Yes. The Bates number is 60.

MR. MADDEN: Yes, ma'am.

THE WITNESS: Yes.

BY MR. MADDEN:

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Q. The top rectangle has some language that says, Opioids have a high rate of abuse and generate enormous costs. Almost 12 percent of opioid patients become addicted.
Do you see that?
A. I do.
Q. Let's compare that with what we saw in Exhibit-12, side by side.
A. Okay.
MR. MADDEN: So if you could go back and highlight the language?
MS. HILLYER: Do you need Exhibit-12?
THE WITNESS: I know what it says.
BY MR. MADDEN:
Q. We have this language about a high rate of abuse with opioid use and this language from Exhibit-12, which was the Actiq managed care dossier, which talks about a low risk of abuse.
Do you see that?

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A. I do.
Q. Would you agree with me that those are contradictory messages?
MS. HILLYER: Objection to form. Lack of foundation as to Exhibit-12. She testified she had nothing to do with that document and has no knowledge of it. It calls for speculation.
BY MR. MADDEN:
Q. I'll ask the question again.
Would you agree with me that those are contradictory messages?
MS. HILLYER: Same objections.
THE WITNESS: I can tell you that the date referenced in the most recent is much -- is recent. I don't know the date of the original document, because I didn't create it.
So the data it's talking about in the dossier was several years prior to this information.

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BY MR. MADDEN:
Q. All right. Would you agree with me that the information is contradictory, regardless of the dates?
MS. HILLYER: Same objections. And objection to form.
THE WITNESS: I believe it's -- new data is available and it's more up to date and more recent, and it's cited. There's no citation in the dossier that I can comment on.
BY MR. MADDEN:
Q. Let's look -- let's go back to Exhibit-12, that same page, 23.
A. Yep.
Q. Under managing the risk of opioid abuse, the first sentence says, Although it is uncommon for chronic pain patients to abuse opioid medication, there is a potential risk associated with the use of all opioids.
Do you see that?

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A. Yes, I do.
Q. Now, let's look at the slide you put together in the Exhibit-20, the following page, which is the Bates number ending in 61.
A. Yep. Yes.
MR. MADDEN: So if you can highlight that first sentence for me?
THE WITNESS: Yep.
BY MR. MADDEN:
Q. And then the slide we see on the right is a slide you put together for Vantrela, correct?
A. Yep.
Q. And you put in that slide the at-risk subpopulation within chronic pain is estimated to be about 27 percent or 602 members per 100,000 plan members.
Do you see that?
A. I do.
Q. And the risk you're talking about there for chronic pain patients is abuse to opioids, correct?

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A. Yes.
Q. Would you agree with me that those two messages are contradictory?
MS. HILLYER: Objection to form. And also lack of foundation as to Exhibit-12.
THE WITNESS: And I'll repeat my answer, which is the -- I don't remember the name, the one to the right of me, the at-risk subpopulation of chronic pain has a reference. It's recent. And I don't know the date of the, or the reference from the previous document, as I did not create it.
BY MR. MADDEN:
Q. Did Vantrela launch?
A. No.
Q. Why?
MS. HILLYER: Objection to the extent it calls for speculation.
THE WITNESS: Yes. I had no part in that decision --

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BY MR. MADDEN:
Q. Were you a part of that decision-making?
A. No, no.
Q. Would you agree with me that Vantrela was designed, according to your slides, to help reduce the risk of abuse of opioids?
A. It was to illustrate that there was an unmet need, potentially, for treatment options for physicians for patients in which they wanted to prescribe a long-acting opioid in an abuse-deterrent formulation.
Q. Right. But we've looked at two slides in your PowerPoint --
A. Yep.
Q. -- specifically dealing with --
MS. HILLYER: Let him finish.
THE WITNESS: Sorry.
BY MR. MADDEN:
Q. -- the incidence of abuse

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for opioid users, correct?
A. Correct.
Q. So Vantrela, at least according to your slides, was designed, at least in part, to deal with that risk of abuse, correct?
A. It was designed, yes, to create a treatment option for physicians to prescribe to patients as they deemed appropriate. It was a non -- that was an abuse-deterrent formulation.
Q. Was there a concern that managed care payers wouldn't pay for Vantrela?
MS. HILLYER: Objection to form.
THE WITNESS: As with any new product, payers are always scrutinizing whether they'll pay for any branded product.
BY MR. MADDEN:
Q. Am I correct that one of the reasons Vantrela did not launch was because there was concern within the

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company, Teva, that third-party payers would not pay for Vantrela?
MS. HILLYER: Objection. Calls for speculation. And lack of foundation. She testified she didn't know why and she wasn't part of that decision.
BY MR. MADDEN:
Q. Do you know one way or the other?
A. I was not part of the decision. I was not part of the decision.
Q. To your knowledge, was the Pain Matters campaign run, in part, to support Teva's generic portfolio?
MS. HILLYER: Objection to form. Calls for speculation. And lack of foundation. She testified she wasn't part of that.
THE WITNESS: I have no knowledge of that.
BY MR. MADDEN:
Q. So as you sit here today,

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you don't know why the Pain Matters campaign was run, as far as supporting any particular product?
A. As far as supporting any particular product, that's correct.
MR. MADDEN: All right. I'll pass the witness.
VIDEO TECHNICIAN: Going off the record --
MS. HILLYER: Can I just do my redirect? You can stay on the record, unless you need to change anything on the record.
THE WITNESS: Do I look straight ahead?
MS. HILLYER: Yes. I'm not going to move over there.
- - -
EXAMINATION
- - -
BY MS. HILLYER:
Q. Ms. Bearer, earlier you testified about an MEP.
Do you recall that?

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A. I do.
Q. Can you explain again what an MEP is?
A. A medical education program.
Q. And in your work at Teva and Cephalon, that would have been in the context of managed care programs?
A. Yes.
Q. And how would an MEP have come about for a managed care program?
A. If a health plan, payer, requested information on any given product, a MIRF would be submitted. And at that point, someone from medical is required to present a medical education program.
Q. Would MEPs have been presented by anybody on the market access team?
A. No.
Q. So they would only be presented to managed care upon an unsolicited request?
A. That's correct.

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Q. Earlier you also testified about the Actiq white paper.
Do you recall that?
A. I do.
Q. How, if at all, was the Actiq white paper used in connection with managed care organizations?
A. Again, upon an unsolicited request, if an account manager is speaking to a payer and they had specific questions relative to any given product that was either -- that the -- at the point in time the account manager could not speak to, they would put a MIRF through -- I'm sorry, medical information request form, and which, then, the white paper would be sent directly to the payer who requested it.
Q. And earlier you looked at sections of the Actiq managed care dossier in Exhibits-11 and 12.
Do you recall that?
A. I do.
Q. And just to clarify, what,

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if any, involvement did you have in creating those documents?
A. None.
Q. Do you know if the versions that are in Exhibit-11 and 12 are final versions?
A. No, I don't.
Q. Do you know if the versions at 11 and 12, Exhibits-11 and 12, were provided to any payers?
A. I -- no.
Q. And over the course of the day, Ms. Bearer, there was some testimony around discussions you or members of the market access team might have had with managed care payers.
Would you or members of managed -- the market access team at Teva or Cephalon ever have substantive discussions concerning the standard of care for disease states other than breakthrough pain in cancer patients who are opioid tolerant in the context of Actiq or Fentora?

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A. No.
MS. RUANE: Object to the form.
BY MS. HILLYER:
Q. Would you have had substantive discussions regarding chronic pain in the context of Actiq or Fentora?
A. No.
Q. Would members of the market access team, to your knowledge, have substantive discussions concerning chronic pain, in the context of Actiq or Fentora, with managed care entities?
MS. RUANE: Object to form.
THE WITNESS: No.
BY MS. HILLYER:
Q. And would you have had substantive discussions concerning acute pain with managed care entities in the context of Actiq or Fentora?
MS. RUANE: Object to form.
THE WITNESS: No.
BY MS. HILLYER:
Q. Would members of the market

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access team have had substantive discussions concerning acute pain with managed care entities, in the context of Actiq or Fentora, to your knowledge?
MS. RUANE: Same objection.
MS. HILLYER: You can answer.
THE WITNESS: Not to my knowledge.
BY MS. HILLYER:
Q. And did Cephalon or Teva have a policy around those types of discussions with managed care entities?
A. Yes.
Q. What was that?
A. If it was not an approved product and/or approved indication, if a question was raised, the policy states that you would say -- you would respond by saying that we're not indicated for whatever the question was, and if you needed additional information, I'm happy to send a MIRF; again, medical information request form.

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Q. And then, lastly, we talked a little bit about Exhibit-16, which was titled, Managed Care Presentation, Draft for Review.
Just to clarify, did you understand this to be a promotional document?
A. No. This is, to me, presented by a speaker.
MS. HILLYER: I have no further questions at this time.
MS. RUANE: Just a few follow-up, briefly.
- - -
EXAMINATION
- - -
BY MS. RUANE:
Q. To be presented by -- the last document you were looking at, that would be to be presented by a speaker who would be a physician compensated by Teva, correct?
A. Correct.
Q. Do you know how much the

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physicians were compensated for speaking and presenting slide decks like the one before you?
A. Fair market value. I don't know what that was.
Q. Do you know how fair market value was calculated?
A. No.
Q. You mentioned that there was a policy regarding an approach -- or a response if there were questions about something beyond the indication.
Is that a written policy?
A. I can't recall --
MS. HILLYER: Objection to form as to time.
BY MS. RUANE:
Q. You can answer if you know.
A. I don't recall -- what time frame are you talking about? Because --
Q. Let's start during the time frame of Teva.
Does Teva have a written policy, to your knowledge, regarding the

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approach taken when a managed care entity has questions about something beyond the indication of a drug?
A. We do have a managed care reimbursement policy.
Q. Is that the title of it, managed care reimbursement policy?
A. I don't recall the exact title of it.
Q. Do you believe that that managed care reimbursement policy has, the policy, a written policy within that consistent with what you just described?
A. To the best of my knowledge. I have not read it recently.
Q. What about during the time of Cephalon, was there a written policy at that time?
A. I don't recall if it was written or not.
Q. You don't have a specific memory of a written policy, during the time that the company was Cephalon, instructing the managed care folks on

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what to do if a managed care entity had a question about something beyond the indication?
MS. HILLYER: Objection to the form. You're talking about a long time frame.
But you can answer.
THE WITNESS: You're asking if there was a written policy?
BY MS. RUANE:
Q. Yes.
A. I don't recall if it was written. I just don't recall if it was written.
Q. Is there anything you can think of where we could look to see a document to confirm your memory that that policy would have existed at the time that the company was Cephalon?
A. Old documents. I don't recall who -- again, we're talking about a long span of time, and there's been an evolution of modules and training and sign-offs on various policies.

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Whoever in the organization is -- compliance, typically, would be the -- I would think -- and, again, that's -- my first answer would be compliance.
Q. Okay.
MS. RUANE: Thank you. Nothing further.
VIDEO TECHNICIAN: Going off record. 3:37 p.m.
- - -
(Whereupon, a discussion off the record occurred.)
- - -
VIDEO TECHNICIAN: Back on record. 3:38 p.m.
- - -
EXAMINATION
- - -
BY MR. GASTEL:
Q. Good afternoon. My name is Ben Gastel, representing the plaintiffs in the Tennessee cases that have been cross-noticed into this deposition today.

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MR. GASTEL: And I first want to state, for the record, that I object to the deposition, on behalf of my clients, going forward today due to Teva's continuous failures to meet its obligations as set forth in the state and federal cooperation protocol, as laid out in our previous deposition records and our pending motions to quash.
With that objection in mind, I do have a handful of questions for you. Hopefully we will be relatively short. I assure you, I will not be as long as your previous questioners today.
BY MR. GASTEL:
Q. As I stated, Ms. Bearer, the group of plaintiffs that I'm representing are located in Tennessee.
So I want to start, in your work with Teva or Cephalon, did you ever have the opportunity to travel to the

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state of Tennessee for your work?
A. Not that I recall.
Q. Would you agree that it's a public health concern whenever prescription opioids are illegally diverted and consumed for nonmedical purposes?
MS. HILLYER: Objection to form.
THE WITNESS: Say it -- repeat the question to make sure I answer you correctly.
BY MR. GASTEL:
Q. Sure.
Would you agree that it's a public health concern whenever prescription opioids are illegally diverted and consumed for nonmedical purposes?
MS. HILLYER: Same objection.
THE WITNESS: Yes.
BY MR. GASTEL:
Q. Would you agree that it's a

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public health concern whenever prescription opioids are consumed for nonmedical purposes?
MS. HILLYER: Objection to form.
THE WITNESS: Can you define "nonmedical purposes"?
BY MR. GASTEL:
Q. Well, in your mind, what are the nonmedical reasons a person would consume a prescription opioid?
MS. HILLYER: Objection to form.
THE WITNESS: You asked the question, so if you could just give me the context of the question.
BY MR. GASTEL:
Q. Well, sure. And so let's take it in two parts here.
In your mind, what are the nonmedical reasons that a person would consume a prescription opioid?
MS. HILLYER: Objection to

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form. Calls for speculation.
THE WITNESS: That would be speculating.
BY MR. GASTEL:
Q. So you don't have in your mind any reason why somebody would consume an opioid for a nonmedical reason?
MS. HILLYER: Objection to form. Calls for speculation.
THE WITNESS: Again, individuals have different reasons for that behavior. I can't speak to it.
BY MR. GASTEL:
Q. Do you have any understanding about why individuals consume opioids for nonmedical purposes?
MS. HILLYER: Same objections. And now asked and answered.
THE WITNESS: Again, I could -- there are probably numerous reasons. And I don't

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have any personal knowledge, personally, of consuming opioids for nonmedical reasons.
BY MR. GASTEL:
Q. Can you get high from consuming prescription opioids?
MS. HILLYER: Objection. Calls for speculation.
THE WITNESS: I have no personal knowledge of whether someone can get high or not, based personally on my own experience.
BY MR. GASTEL:
Q. And you've never heard of people getting high off of prescription opioids?
A. I hear a lot of things. So, again, you're asking me specifically about my interpretation of getting high.
And I -- as far as having an opinion about that, I know what I hear in the media. But no personal experience with that.
Q. I'm not asking you if you've

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ever been high.
I'm asking you if you have an understanding of whether or not people get high from prescription opioids?
MS. HILLYER: Hold on. Asked and answered. She's testified that she's heard in the news about this, she has no personal experience.
She's here as a fact witness to testify about her personal experience.
If you want to ask her about that, go ahead. But she's answered your question.
MR. GASTEL: Are you directing her not to answer?
MS. HILLYER: No.
BY MR. GASTEL:
Q. You can answer.
A. I have no personal experience relative to individuals getting high off of opioids.
Q. In 2015, did you believe

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that there was a public health crisis of abuse and addiction as it relates to opioids?
MS. HILLYER: Objection to form.
THE WITNESS: Did I have a personal -- repeat it, I'm sorry. I'm just --
BY MR. GASTEL:
Q. In 2015 --
A. 2015.
Q. -- did you believe that there was a public health crisis of abuse and addiction as it relates to opioids?
MS. HILLYER: Same objection.
THE WITNESS: Yeah, I don't -- you're asking my personal belief?
BY MR. GASTEL:
Q. Yes.
A. Again, with no firsthand knowledge, but data would suggest, in the public domain, that that is correct.

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Q. I'll show you a document that we'll mark as Exhibit-22.
- - -
(Whereupon, Teva-Bearer Exhibit-22, TEVA_MDL_A_09218160-165, was marked for identification.)
- - -
MR. GASTEL: I've got a copy for you, too.
MS. HILLYER: Thank you.
BY MR. GASTEL:
Q. You see that Exhibit-22 is an e-mail that you sent to various individuals on June 4th, 2015?
Do you see that?
A. I do see that.
Q. And the subject is the Time Magazine Cover Story, Why America Can't Kick Its Painkiller Problem.
Did I read that correctly?
A. Yes.
Q. And then in the subject of the e-mail you write, All, more news

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highlighting the public health crisis of abuse and addiction. Regards, Deb.
Did I read that correctly?
A. You did.
Q. And the e-mail goes on to forward this cover story for Time Magazine.
And if we go to the last page of this exhibit, there is a picture of the cover of the Time Magazine article, and the cover says, They're the most powerful painkillers ever invented and they're creating the worst addiction crisis America has ever seen.
Did I read that correctly?
A. Yes.
Q. And you forwarded this to some of your colleagues at Teva, correct?
A. Yep.
Q. And it looks like you also included some people from Insight Strategies?
A. Yes.
Q. Who are Steve Reid and Harry

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Schiavi?
A. Yes, Schiavi.
They work for a managed care -- they are strategic partners, a third party, that have conducted payer research, analog assessment, et cetera.
Q. So they were a vendor --
A. Correct.
Q. -- that Teva would use as part of its marketing and promotion to managed care organizations?
A. Correct.
Q. And why did you think it was important that they saw this Time Magazine article?
MS. HILLYER: Objection to form.
THE WITNESS: As I stated previously, there was a lot of information in the public domain concerning this. And, therefore, I felt it was important, as we as an organization were looking at abuse, this was in preparation for

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Vantrela. That would be the reason.
BY MR. GASTEL:
Q. Sure.
And then -- now that you've looked at this e-mail, does this refresh your recollection that in 2015 you believed that there was a public health crisis of abuse and addiction?
A. I said this is news highlighting the public crisis, that was in the public domain.
You asked me previously if it was my personal. And I answered the question that I have no personal experience with any individual or individuals experiencing opioid addiction.
Q. And that's fine.
But you're the one who chose the language that's used in this e-mail, right?
A. That's correct.
Q. And if you didn't believe

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that we were in the midst of a public health crisis of abuse and addiction, why did you use that in your e-mail?
A. I didn't say that --
MS. HILLYER: Objection to form.
THE WITNESS: What I'm saying to you is, this is the type of information that payers are also -- it's public information.
And as it relates to our customers, they read this information as well.
BY MR. GASTEL:
Q. I want to go through some of the things that this article highlights.
The last paragraph on the first page ending in 160, do you see where it starts, This is not?
Are you with me?
A. That paragraph, yes. This is not a story.
Q. It says, This is not a story about dark alleys and drug dealers. It

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starts in doctors' offices with everyday people seeking relief from pain and suffering. Around the nation, doctors so frequently prescribe the drugs known as opioids for chronic pain from conditions like arthritis, migraines, and lower back injuries, that there are enough pills prescribed every year to keep every American adult medicated around the clock for a month.
Did I read that correctly?
A. You did.
Q. When you forwarded this article to your colleagues at Teva and your third-party vendors that you worked with, did you agree with that statement in this article?
MS. HILLYER: Objection to form.
THE WITNESS: That's not referenced. It's simply what was written.
If they put a reference, I would have more reason to have an

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opinion. I would have an opinion.
BY MR. GASTEL:
Q. The paragraph goes on there, The longer patients stay on the drugs, which are chemically related to heroin and trigger a similar biological response, including euphoria, the higher the chances users will become addicted.
Did I read that correctly?
A. You did.
Q. When you forwarded this article to your colleagues at Teva and your third-party vendors, did you agree with this statement made in this article?
MS. HILLYER: Objection to form.
THE WITNESS: I didn't have an opinion about this statement when I forwarded the e-mail.
BY MR. GASTEL:
Q. Do you have an opinion now?
A. There's no reference here specific to what they're quoting. And as I mentioned earlier, there's a lot of

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information in the public domain, which we take seriously, and we, obviously, were looking at an abuse-deterrent treatment option for patients physicians deemed appropriate for an abuse-deterrent formulation of opioids.
Q. Are you done?
A. Yeah, I'm sorry.
Q. That's all right. I was just making sure you were done.
The article goes on. When doctors, regulators and law enforcement officials try to curb access, addicted patients buy pills on the black market, where they are plentiful.
Did I read that correctly?
A. Yes, you did.
Q. When you forwarded this article to your colleagues at Teva and your third-party vendors, did you agree with this statement made in this article?
MS. HILLYER: Objection to form.
THE WITNESS: I didn't have

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an opinion about that -- that statement.
BY MR. GASTEL:
Q. Going down farther into the next paragraph, the sentence beginning, Of the 9.4 million Americans who take opioids.
Do you see that?
A. Where am I looking at?
Q. The third line down, three-quarters of the page over.
A. I see it. Thank you.
Q. It says, Of the 9.4 million Americans who take opioids for long-term pain, 2.1 million are estimated by The National Institutes of Health to be hooked and are in danger of turning to the black market.
Did I read that correctly?
A. Yes.
Q. When you forwarded this article to your colleagues at Teva, did you have any reason to dispute this statistic from The National Institutes of

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Health as relayed by this Time Magazine article?
MS. HILLYER: Objection to form. Lack of foundation.
THE WITNESS: Did I have any reason to dispute it?
BY MR. GASTEL:
Q. Yes.
A. Again, other than the reference to The National Institutes of Health, of which I've not seen the actual data, this is just a statement to me, of which I don't have an opinion if it's accurate or not.
Q. Did you ever tell any of your colleagues that you thought that The National Institutes of Health was overestimating the number of Americans that are hooked and in danger of turning to the black market?
A. I don't have any recollection of having a conversation.
Q. Going down, skipping down two paragraphs with the paragraph

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beginning, All now agree.
Do you see that?
A. Yes.
Q. About a quarter of the way down the page.
All now agree that the opioid epidemic is a terrible problem, but few are taking responsibility. It has fallen to local law enforcement and health professionals to clean up the mess as addiction and abuse ravage their communities.
Did I read that correctly?
A. Yes, you did.
Q. When you forwarded this e-mail to your colleagues at Teva and your third-party vendors, did you have any reason to dispute that claim in the Time Magazine article?
MS. HILLYER: Same objections.
THE WITNESS: Once again, there's no specific reference to where they cite this data.

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Therefore, I don't have an opinion.
BY MR. GASTEL:
Q. Did you tell any of your colleagues, or do you recall telling any of your colleagues, that you thought Time Magazine was wrong when they claimed that local law enforcement and health professionals were left to clean up the mess?
MS. HILLYER: Objection to form.
THE WITNESS: I don't recall having any conversation.
BY MR. GASTEL:
Q. I'm going to flip over to the next page, the one ending with Bates stamp 162.
A. Okay.
Q. And about halfway down, there's a paragraph beginning, In some cases.
Do you see that paragraph?
A. I'll read it here.

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Okay. Got it. Thank you.
Q. It says, In some cases, regulators, doctors and patients were criminally misled into believing opioids were safe and effective. In 2007, the Department of Justice accused Purdue of deceptively telling doctors that OxyContin was safer and less addictive than other drugs.
Did I read that correctly?
A. You did.
Q. When you forwarded this to your colleague at Teva and your third-party vendors, did you know about the Department of Justice accusing Purdue of deceptively marketing OxyContin?
A. I don't recall whether I knew at that time or not, when I forwarded the message. The message was forwarded almost three years ago. So I don't recall.
Q. Do you -- did you subsequently do research into the Department of Justice's accusations

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against Purdue about its deceptive marketing of OxyContin?
A. I don't recall doing any research into the Department of Justice.
Q. Are you aware of whether or not the Department of Justice brought criminal charges against Purdue in Virginia, near the Tennessee border?
A. I have -- no, I don't know.
MS. HILLYER: Objection.
Assumes facts not in evidence.
BY MR. GASTEL:
Q. That paragraph goes on to say that, The company and several executives pleaded guilty to misleading doctors and were fined $635 million.
Did I read that correctly?
A. You did.
Q. Did you know about Purdue's guilty plea and their fine of $635 million when you forwarded this e-mail?
A. I can't speak to what I knew at the time I forwarded the e-mail.
Q. The paragraph goes on to

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talk about something that you probably do have knowledge on.

It says, In 2008, Cephalon paid $425 million in fines, partly for marketing its Actiq opioid, which was shaped like a lollipop, for use against migraines and sickle-cell pain, conditions for which the drug had not been found safe and effective.

Did I read that correctly?

A. You did.

Q. And then the article goes on to say, Actiq withdrew its lollipop but by then there was no shortage of other opioids available.

Did I read that correctly?

A. You did.

Q. When you forwarded this article to your colleagues at Teva and your third-party vendors, you were aware that Cephalon had paid the $425 million fine, correct?

A. Correct.

Q. And that that was, in part,

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due to its marketing of Actiq opioids, correct?

A. In part.

Q. Is that a yes?

A. Yes, in part.

I'm sorry.

Q. And in 2008, did you personally have a role in marketing Cephalon's Actiq product?

MS. HILLYER: Objection to the form.

THE WITNESS: 2008?

BY MR. GASTEL:

Q. Yes.

A. Yes.

Q. I think I'm done with that article.

- - -

(Whereupon, Teva-Bearer Exhibit-23, TEVA_MDL_A_03967973-979, was marked for identification.)

- - -

MR. GASTEL: I'm going to

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hand you another document that we'll mark as Exhibit-23.

BY MR. GASTEL:

Q. This is an e-mail from Yousseff Kahn, sent to a variety of people, including you, on August 24th, 2015.

Do you recall receiving this e-mail?

A. I don't actually recall, but I must have received it. I'm on the e-mail chain.

Q. Sure.

And the subject is, CI news, opioid use disorder, the continued rise of opioid abuse and misuse.

Did I read that correctly?

A. You did.

Q. And it appears to be an article written by Bill McCarberg.

A. Yes.

Q. Are you familiar with Dr. McCarberg?

A. I know the name, but I don't

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know specifically Dr. McCarberg.

Q. And going down to the second full paragraph beginning, In 2013.

Do you see that?

A. Yes.

Q. The article states, In 2013 in the United States, 40,982 deaths by drug overdose occurred. Of these, 16,235 were the result of opioid analgesics.

Did I read that correctly?

A. You did.

Q. And the article states that that's equivalent to 46 deaths every day.

Did you have any reason to dispute those statistics when you received this e-mail in August of 2015?

A. I don't have the references. If it's referenced, then I would have no reason to dispute it, until I read the reference and determined whether it was appropriate or not.

Q. And the article goes on to state that, While the age-adjusted rate for drug overdose deaths related to

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opioids increased at a rate of 19 percent per year from 2000 to 2006, the rates slow down from 2 percent from 2006 to 2013.

Did I read that correctly?

A. Yes.

Q. It says, The age-adjusted rate for opioid overdose deaths declined from 5.4 to 5.1 per 100,000 from 2010 to 2013.

Did I read that correctly?

A. Yes.

Q. Do you have any reason to doubt that those statistics were accurate when you received this e-mail back in 2015?

A. Again, I don't recall receiving it. Therefore, I don't know what my impression was at the time.

It appears -- I don't see a reference.

Q. And then --

A. Yes, it is referenced. Sorry.

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Q. Assuming those statistics are true --

A. Yes.

Q. -- would you characterize that, personally, as an opioid crisis?

MS. HILLYER: Objection to form. Lack of foundation. Calls for speculation.

THE WITNESS: Opioid crisis?

MS. HILLYER: And assumes facts not in evidence.

THE WITNESS: Yeah, based on this article, I would not -- I would not -- I don't recall ever having a personal discussion or professional discussion around -- based on this article. The crisis, I don't recall that.

BY MR. GASTEL:

Q. And so --

A. The crisis.

Q. -- we've looked now at a couple of articles that you received in 2015 as it relates to what you described

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as the public health crisis of abuse and addiction.

And I think your testimony previously was that you started receiving these when you were putting together business plans and marketing promotional efforts for Vantrela; is that correct?

MS. HILLYER: Objection. Mischaracterizes testimony on a couple of counts.

But you can answer.

THE WITNESS: The way I'm making that -- I'm giving that information is based on the date.

BY MR. GASTEL:

Q. Sure.

A. In preparation -- if the date aligned with preparation for the strategy, et cetera, for Vantrela, then the answer would be yes.

Q. And what do you mean by the strategy for Vantrela?

A. The payer strategy, as was described previously for any product.

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Q. And the payer strategy being the way that you were going to promote in marketing -- and market Vantrela to third-party payers, right?

A. Correct.

Q. And a big part of that was going to be promoting it as an abuse deterrent, correct?

A. Correct.

Q. And you were going to do that because the opioids on the market were subject to abuse and misuse, correct?

MS. HILLYER: Objection to form.

THE WITNESS: There were abuse-deterrent formulations available, as well as nonabuse-deterrent formulations available.

BY MR. GASTEL:

Q. Well, we have just gone through some articles going through -- that you forwarded and that you received

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talking about opioid abuse, right?
A. Right.
Q. And so -- and you believe that you received these articles as part of developing the Vantrela payer strategy, right?
A. Correct. Yes.
Q. And it would only make sense to market Vantrela as an abuse deterrent to these third-party payers if they were on the market at that time, prescription opioids, that were subject to abuse, right?
MS. HILLYER: Objection to form.
THE WITNESS: Once again, it's a treatment option the physicians would have, based on identifying appropriate patients, that they could then determine if an abuse-deterrent formulation of an opioid was appropriate.
BY MR. GASTEL:
Q. And so do you recall the

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active opioid ingredient in Vantrela?
A. Hydrocodone.
Q. And was the purpose of trying to sell Vantrela an attempt to displace some of the current hydrocodone market?
MS. HILLYER: Objection to form.
THE WITNESS: It was, again, another option for physicians, when they determined it was appropriate to prescribe for a patient an abuse-deterrent formulation, which is just another treatment option.
- - -
(Whereupon, Teva-Bearer Exhibit-24, TEVA_MDL_A_03551263-266, with attachment, was marked for identification.)
- - -
BY MR. GASTEL:
Q. Let me show you a document

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that we'll mark as Exhibit-24.
MR. GASTEL: This is actually Exhibit-2.
MS. HILLYER: Do you have a copy for me?
MR. GASTEL: Yes, I'm sorry.
MS. HILLYER: That's okay. Thanks.
BY MR. GASTEL:
Q. So this is a long e-mail string that begins on March 11, 2016. And it looks like you are eventually forwarded this string on Thursday, April 14th, 2016.
Do you see that?
A. Yes, I do.
Q. Do you recall receiving this e-mail?
A. I don't recall.
Q. Let's flip through it a little bit and set the stage, if you will.
The e-mail chain begins with an e-mail from Jeffrey Callahan --

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A. Correct.
Q. -- to Dana Kelly on March 11, 2016.
Do you see that?
A. I do.
Q. Who is Mr. Callahan?
A. He was in forecasting.
Q. And who is Ms. Kelly?
A. Finance.
Q. And it says, Good morning, Dana. Attached is the template that provides you with units for new IR hydro and oxy scenarios that we constructed yesterday.
Did I read that correctly?
A. You did.
Q. And IR hydro and oxy is a reference to immediate-release hydrocodone and Oxycodone?
A. Correct.
Q. And those are prescription opioids, right?
A. Yes.
Q. And it looks like Mr.

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Callahan forgot to attach the document.
And so he sends another e-mail that says, It would help if I remembered to attach the file.
Do you see that?
A. Yes, I do.
Q. And then on March 15th, 2016, Ms. Kelly responds, Hello. Please find the LRP units for IR hydro and oxy attached.
Did I read that correctly?
A. Yes.
Q. What does "LRP units" mean?
MS. HILLYER: Objection to the extent it calls for speculation.
THE WITNESS: I don't know.
BY MR. GASTEL:
Q. Well, I'm happy that I can also be confused on that term, then, too.
Going back up, eventually when you joined the e-mail chain, I believe, on April 14th, 2016, at the top of the second page of this document, with

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Bates stamp ending 264, Mr. Jeffrey Dierks forwards you this e-mail chain.
Do you see that?
A. I do.
Q. I think you've previously testified.
But just again for the record, who is Mr. Dierks?
A. He was the brand director for Vantrela.
Q. And in his role as brand director for Vantrela, he was the person who was principally involved in attempting to market and develop promotional material for Vantrela; is that fair?
A. His team, yes.
Q. And it says, Deb, welcome any of your thoughts on the below, as we need to finalize some of the assumptions for the development of the IR P&Ls.
Did I read that correctly?
A. Yes.
Q. And is the term "IR P&Ls" a

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reference to immediate-release profit and loss?
A. Yes.
Q. So is it fair to say that Mr. Dierks is at least partly trying to figure out with this analysis whether or not Teva could make money from marketing and selling Vantrela?
MS. HILLYER: Objection. Calls for speculation.
THE WITNESS: This, as I read it, is in reference to another product, Valzedo, which we were looking potentially -- and, again, I'm reading this, so I believe this is what it was referring to, not Vantrela -- Valzedo, which was an immediate-release version of hydrocodone.
BY MR. GASTEL:
Q. And so eventually you, again, flipping over to the next page, you send an e-mail to Joseph Smith.

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Do you see that?
A. Yes.
Q. And it says, What were the assumptions by channel? I know we typically assume 78 -- 70 to 80 percent commercial. With the new forecast, did anything change?
Did I read that correctly?
A. You did.
Q. What does that mean, that "we typically assume 70 to 80 percent commercial"?
A. Well, when we look at the patient population for branded products, we assume, based on data, that 70 to 80 percent of the patients will have commercial insurance for which we are promoting the product.
And I'm asking if that changed, because Joe also is a forecaster.
Q. Got it.
And then he responds back with this breakdown, right, in the e-mail

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dated April 18th, 2016 at 7:10 a.m.?
Do you see that?
A. Yes.
Q. And it says, Was looking for you Friday and just connected with Jeff and found out you were out until Thursday. I'd assume the below splits based off the IMS data, since they probably won't change significantly.
Did I read that correctly?
A. Yes.
Q. And then he provides a breakdown between Medicaid, cash, commercial, and Part D --
A. Yes.
Q. -- correct?
A. Yes.
Q. And this is, essentially, various ways that end users of prescription opioids can pay for those opioids, right?
A. That, you know, are reimbursed.
Q. And what do you mean by

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"reimbursed"?
A. Your question, I believe, was about patients. Patients pay cash. Medicaid, commercial and Part D are insurers. Therefore, the insurer reimburses, for the patient, the cost of the drug.
Q. And then the reference to IMS data, that's IMS Health data, right?
A. Yes.
Q. For the record, will you just explain what IMS data is?
MS. HILLYER: Objection to the extent it calls for speculation.
THE WITNESS: They have a variety of data. And its claims data, prescription -- typically, claims data. And it's used for -- to assess utilization.
BY MR. GASTEL:
Q. Sure. And I want to take a look at some of this IMS data that you were forwarded in this e-mail from Mr.

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Joseph Smith on April 18th, 2016. And it's attached to Exhibit-24.
A. Okay.
Q. And I believe it's the fifth page of this exhibit.
And it says, across the top -- it's an Excel spreadsheet --
MS. HILLYER: Sorry, again, just for the record, these are not consecutive Bates.
MR. GASTEL: Yeah, well, it's the attachment to the April 18th, 2016 e-mail.
MS. HILLYER: Then it would be consequent -- there's no attachment. Which April 18th?
MR. GASTEL: From Joseph Smith.
MS. HILLYER: So the middle, the second e-mail chain, okay.
So do you have that -- it's just not consecutive, so we don't actually have, sitting here today --

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MR. GASTEL: I don't Bates stamp them, you Bates stamp them.
MS. HILLYER: I do.
MR. GASTEL: If you want the exhibits consecutive with the e-mails they're attached to, Bates stamp them that way.
MS. HILLYER: We do. This is not a consecutive -- there's no attachment to this top e-mail, which has no attachment, so it is consecutively Bates, if it was attached to the second. You just didn't print that out and bring it as an exhibit. And that's not our fault.
And I just want to make it clear for the record that there's two different Bates numbers and you should probably put in the record what those Bates numbers are for future reference, so nobody gets confused.
MR. GASTEL: Well,

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regardless, the attachment is -- was produced natively to us as Bates stamp document TEVA_MDL_A_03550081.
BY MR. GASTEL:
Q. And across the top on this document it says, Product.
Do you see that?
A. Yes.
Q. And that would indicate that this is the product of IMS Health data that's been collected, correct?
A. Yes. It would appear that, yes.
Q. And the next column over, it says, MAT, March 2014, Medicaid TRx.
Do you see that?
A. I do.
Q. Is that a -- is that a reference to a monthly average total?
MS. HILLYER: Objection to the extent it calls for speculation.
THE WITNESS: I don't know.

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I didn't run the report.
BY MR. GASTEL:
Q. But you received it, right?
A. Well, to the point you made earlier, just because it says -- I don't know -- this was a long trail of forwarded. It doesn't necessarily mean he forwarded me the attachment.
I don't recall receiving it, is what I'm trying to say.
Q. Well, let's go back to the e-mail chain there.
Because it finishes off with an e-mail from you to Joseph Smith that says, Sorry I missed you on Friday. As of now, I would use these assumptions.
A. Yes.
Q. Right? That's what it says?
A. That has nothing to do with the attachment. That's these assumptions at the bottom here, the channel --
Q. So --
A. -- not at the bottom, the Medicaid, cash --

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MS. HILLYER: Wait. One at a time.
THE WITNESS: Pardon me?
MS. HILLYER: One at a time.
BY MR. GASTEL:
Q. So that doesn't refresh your recollection as to whether or not you looked at the attachment?
MS. HILLYER: Objection to form. Improper refreshing. And mischaracterizes the document.
THE WITNESS: Typically, this type of data is summarized by either someone in forecasting, et cetera. And this is the summary that I would have looked at, rather than scrutinizing the Excel sheet.
BY MR. GASTEL:
Q. Sure. So you would have --
A. They are the experts on IMS data.
Q. So you would have looked at the analysis, is that what you're saying,

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to determine whether or not the assumptions were correct?
A. I don't recall ever receiving this document. These colleagues are the experts in our company that provide forecasting information. I would have no reason to challenge their summary, which, to me, is what I'm looking at here, which is Medicaid, cash, commercial, Part D.
Q. Well, let's go to the last page, then.
A. Okay.
Q. Okay. And you see that the last page of this document has some numbers on it.
Let's do the second-to-last page, okay? Do you see that it has -- the very bottom page says, Medicaid, 4,339,185, 4.62 percent.
Do you see that?
MS. HILLYER: No.
BY MR. GASTEL:
Q. Very last column.

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A. I see that, yes.
Q. So go back to the e-mail that you received --
A. Yes.
Q. -- on April 18th, 2016.
And it says, Medicaid, the exact same numbers and exact same percentage.
Do you see that?
A. I do.
Q. Let's flip to the last page, the one labeled cash, 6,658,519, 6.99 percent.
Do you see that?
A. I do.
Q. Let's go back to your e-mail that you received on April 18th, 2016.
Exact same numbers for cash, right?
A. Yes.
Q. Commercial, last page, 57,485,347, 60.36 percent.
Do you see that?
A. I do.

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Q. And I read that correctly?
A. I believe you did.
Q. And then it's the exact same number in the e-mail of April 18th, 2016, right?
A. Right.
Q. And then Part D, again, on the last page, 26,699,350.
Did I read that correctly?
A. You did.
Q. 28.03 percent.
Did I read that correctly?
A. You did.
Q. And then if you flip back to the e-mail on April 18th, 2016, it's the exact same numbers there in that e-mail, right?
A. Yes.
Q. To which you responded, You can use those assumptions, right?
A. Yes.
Q. And then if you take a look at what that document is summarizing, again, going back to the second-to-last

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page, you see, in what is essentially the product column, it's HYCD/APAP.
All the way down.
A. I see.
MS. HILLYER: This is what he's looking at.
THE WITNESS: No, I know what he's looking at. I'm looking at the previous to see -- yes. Okay.
BY MR. GASTEL:
Q. And is it your understanding that that's a reference to hydrocodone with acetaminophen?
A. Yes.
Q. And so according to this IMS Health database that you were forwarded on April 8th, 2016, there were approximately, if I'm doing my math right, 95 million prescriptions for these hydrocodone products?
MS. HILLYER: Objection. Calls for speculation. Lack of foundation. She's testified she

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doesn't recall ever receiving this, reviewing it, and had nothing to do with it.
MR. GASTEL: She received the e-mail that has this data in it. And she told --
MS. HILLYER: She doesn't recall that. And she said --
MR. GASTEL: And she told her colleague --
MS. HILLYER: Hold on. Let me state my objection.
MR. GASTEL: -- that she -- that he can go ahead and use the assumptions.
MS. HILLYER: For the record, she testified that she doesn't recall receiving this. This document doesn't reflect that she received this. She testified that the assumptions were in reference to the substance of what he wrote in the underlying e-mail, not in this attachment.

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You can ask your question and she can answer it. But my objections are on the record.
THE WITNESS: Rephrase, sorry.
BY MR. GASTEL:
Q. So if I'm doing my math right, that's 95 million prescriptions, right?
MS. HILLYER: Same objections.
THE WITNESS: Well, I'm not adding it up, so I'll -- if you want to add all this together and it comes to that, I'll believe you.
BY MR. GASTEL:
Q. Well, let's just do simple math.
What's 56 plus 26?
A. Okay. I got you.
MS. HILLYER: You're asking her to do the math?
THE WITNESS: You're asking

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me to do the math?
MS. HILLYER: Give her a calculator. I mean, come on, she's here as a fact witness. This is -- I mean, at some point --
MR. GASTEL: You're the one who is making this hard. Don't get mad at me.
MS. HILLYER: If you want her to do the math, give her --
MS. GASTEL: You're the one who's making this hard.
MS. HILLYER: -- put the math up there.
No, I'm not. She has nothing to do with this document.
And somebody asked for a break. So after this answer, we'll take a break.
And just for the record, Ms. Bearer, why don't you state what you're actually doing, the math.
THE WITNESS: I'm taking the

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totals that were provided on the e-mail for the channels of Medicaid, cash, commercial and Part D, and I'm adding them together.
Unless I did it incorrectly, it comes to -- what I show, unless I made a mistake, it's 95,242,401.
MS. HILLYER: Just leave it, in case there's more math.
BY MR. GASTEL:
Q. And that was derived, according to this e-mail, from the IMS data that Joe sent to you on April 18th, 2016?
MS. HILLYER: Objection to form. You're asking her whether the number she just put into the calculator was derived from the IMS data in this e-mail?
MR. GASTEL: Yes.
MS. HILLYER: Objection to form. Same objections. Lack of foundation. Calls for

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speculation. She testified that she doesn't know that she received the attachment.
Go ahead.
THE WITNESS: I don't --
BY MR. GASTEL:
Q. The e-mail itself references the IMS data, right?
A. So --
Q. And you have no reason to doubt that Joe is -- that Joe, when he forwarded this e-mail on April 18th, 2016, was lying to you that the source of this material was IMS data, right?
A. No.
MS. HILLYER: Objection to form.
THE WITNESS: I don't have any reason to suggest he lied. His role is very different than mine.
BY MR. GASTEL:
Q. Sure.
A. So if he runs the data, then

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I don't go back and do what you asked me to do, which is add it up.
Q. Sure.
A. I don't.
Q. And then you respond that, As of now, I would use those assumptions, right?
A. Yes.
Let me be clear. For the -- what were the assumptions by channel, we're talking percentages.
Q. Sure. But the percentages are based on these prescription numbers, right?
A. Yes.
Q. And that's 95 million prescriptions, right?
MS. HILLYER: Objection to form.
THE WITNESS: Based on the calculator that you provided me and my adding it up, that's what the number came to.
BY MR. GASTEL:

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Q. Does that sound like a lot of prescriptions to you, 95 million?
MS. HILLYER: Objection to form.
THE WITNESS: Compared to what?
BY MR. GASTEL:
Q. Compared to anything.
MS. HILLYER: Objection to form.
THE WITNESS: I don't have a -- I mean, it's a large number, I'll agree to that. It's a large number.
MS. HILLYER: Let's go off the record.
VIDEO TECHNICIAN: Going off the record. 4:27 p.m.
- - -
(Whereupon, a brief recess was taken.)
- - -
VIDEO TECHNICIAN: Back on record. 4:35.

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BY MR. GASTEL:
Q. Going back to the Time Magazine article, flipping to the document Bates labeled 62, which I believe is the third --
MS. HILLYER: Which exhibit number?
BY MR. GASTEL:
Q. -- the third page.
MS. HILLYER: What exhibit?
MR. GASTEL: 22. The Time Magazine article.
THE WITNESS: What page? I didn't hear you. I'm sorry.
BY MR. GASTEL:
Q. 162.
A. Okay.
Q. About a little over halfway down the article, it says, By 2011 -- do you see that paragraph beginning?
A. Yes.
Q. By 2011, the number of opioid prescriptions written for pain treatment had tripled to 219 million.

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Did I read that correctly?
A. Yes, you did.
Q. And we just looked at some IMS Health data that suggested that there were 95 million prescriptions for hydrocodone.
Does the number 219 million cause you any concern?
MS. HILLYER: Objection to form.
THE WITNESS: I mean, again, reading this out of context, there's no reference. Therefore, I don't have an opinion.
BY MR. GASTEL:
Q. Well, when you forwarded this article to your colleagues at Teva and your third-party vendors and you saw that Time Magazine was reporting prescription rates of 219 million, did that cause you concern at the time?
MS. HILLYER: Objection to form.
THE WITNESS: This is

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information that was in the public domain that our customers would see. And, therefore, the purpose of forwarding it on was looking at the landscape, we're preparing to launch an abuse-deterrent formulation.
BY MR. GASTEL:
Q. And you're preparing to launch an abuse-deterrent formulation because there was widespread abuse and addiction of opioids, right?
MS. HILLYER: Objection to form. And asked and answered.
MR. GASTEL: Let me rephrase.
THE WITNESS: Yeah, okay.
BY MR. GASTEL:
Q. You were planning on launching an abuse-deterrent formulation in order -- in response to what you described as the public health crisis of abuse and addiction, right?
MS. HILLYER: Objection to

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form. And mischaracterizes the document and the testimony.
You can answer.
THE WITNESS: This was an article on the public health crisis, which we monitored everything that was -- you know, we tried to keep current with what was in the public domain.
BY MR. GASTEL:
Q. But the term "public health crisis of abuse and addiction" is your term; it's in your cover e-mail?
A. That's correct.
Q. That was the language that you chose to use, right?
A. That's correct.
MR. GASTEL: Subject to my previous objection -- oh, let me ask -- I'm sorry, let me ask one last question.
BY MR. GASTEL:
Q. Where do you live, Ms. Bearer?

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A. Pennsylvania.
Q. What is your actual address?
A. 27 Post Run, Newtown Square, Pennsylvania.
Q. And who lives there with you?
A. No one.
MS. HILLYER: Objection to form.
BY MR. GASTEL:
Q. Do you have any plans to move any time soon?
A. I don't really have an opinion, at this point, of whether I'm going to move or not.
Q. Do you own that residence?
MS. HILLYER: Objection.
THE WITNESS: Yes.
MR. GASTEL: All right. Subject to my previous objection, Ms. Bearer, thank you for your time. I have no more questions today.
THE WITNESS: Okay.

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MS. HILLYER: Just to respond to your previous objection, Teva is not in violation of any protocol or guidance concerning the state and federal protocol.
We produced everything in a timely manner and answered all of the questions that you had.
I do have a few brief redirect questions for Ms. Bearer.
- - -
EXAMINATION
- - -
BY MS. HILLYER:
Q. Ms. Bearer, do you recall, when was the launch of Fentora?
A. 2007.
Q. Would you or anyone at Teva have -- or Cephalon, excuse me, have marketed Actiq after the launch of Fentora?
A. No.
Q. Did you ever market or

promote Actiq for off-label uses?
A. No.
Q. Did you ever market or promote Fentora for off-label uses?
A. No.
MS. HILLYER: I have no further questions.
Off the record.
VIDEO TECHNICIAN: This ends today's deposition. Going off the record at 4:40 p.m.
- - -
(Whereupon, the deposition concluded at 4:40 p.m.)
- - -

CERTIFICATE

I HEREBY CERTIFY that the witness was duly sworn by me and that the deposition is a true record of the testimony given by the witness.

Amanda Maslynsky-Miller
Certified Realtime Reporter
Dated: January 9, 2019

(The foregoing certification of this transcript does not apply to any reproduction of the same by any means, unless under the direct control and/or supervision of the certifying reporter.)

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Please read your deposition over carefully and make any necessary corrections. You should state the reason in the appropriate space on the errata sheet for any corrections that are made.

After doing so, please sign the errata sheet and date it.

You are signing same subject to the changes you have noted on the errata sheet, which will be attached to your deposition.

It is imperative that you return the original errata sheet to the deposing attorney within thirty (30) days of receipt of the deposition transcript by you. If you fail to do so, the deposition transcript may be deemed to be accurate and may be used in court.

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ACKNOWLEDGMENT OF DEPONENT

I,______________________, do hereby certify that I have read the foregoing pages, 1 - 374, and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

____

DEBORAH BEARER DATE

Subscribed and sworn to before me this _____ day of ______________, 20____.

My commission expires:______________

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Notary Public

LAWYER'S NOTES

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